Structural barriers to treatment for pregnant Coloured women abusing TIK in Cape Town: The experiences of healthcare providers

by

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Declaration

By electronically submitting this thesis, I declare that content therein, it its entirety, is my own, original work and that I have full authorship and ownership thereof. I have not previously submitted this work, in part or in entirety, for the obtaining of any qualification.

	March 2017
Signature	Date

Abstract

Despite interventions that aim to address the barriers to healthcare treatment for pregnant Coloured women abusing TIK in Cape Town, the rate of accessing substance abuse treatment and maternal care amongst this population remains dismally low. Recent literature has given attention to highlighting the structural barriers to treatment as experienced from the perspective of pregnant Coloured women; however, little, if any, research has been conducted on these barriers from the healthcare providers' perspective.

The present study thus aimed to identify the structural treatment barriers experienced by healthcare providers who treat pregnant Coloured women who abuse TIK. An exploratory qualitative design was utilised whereby 20 healthcare providers were identified through purposive sampling and subsequently interviewed. All participants are involved in the treatment of pregnant Coloured women who abuse TIK. Semi-structured interviews allowed for the documentation of healthcare providers' experiences of the barriers that they encounter when treating Coloured pregnant women who abuse TIK. Thematic analysis was applied in order to generate and analyse themes that emerged from the data collected during the semi-structured interviews.

Various barriers were identified and were categorised as: overburdened and under-resourced healthcare providers, the effect of the work place on healthcare providers' home life, challenges with referral, factors hindering treatment that are outside the healthcare providers' control, miscommunication, and lack of funding.

Bronfenbrenner's (1979) Ecological Systems Theory was used to conceptualise each theme on the five levels that constitute his theory. Each theme was discussed as a micro-, meso-, exo- or macro-system level barrier and was linked to current literature on healthcare providers' experiences of barriers to treatment. Although barriers found within the present study are consistent with the barriers found in current literature, novel barriers found within the healthcare referral system have posed as a significant problem specifically regarding the treatment of pregnant Coloured women abusing TIK.

Despite the incorporation of substance abuse treatment into various outpatient and primary healthcare facilities in Cape Town, which was aimed at addressing the fragmentation of substance abuse treatment and maternal services, a gap in this system for pregnant

Coloured women abusing TIK endures. As Coloured pregnant women that abuse TIK are classified as high risk, outpatient and healthcare providers employed at primary healthcare facilities cannot provide treatment for these women. Healthcare providers are thus forced to refer pregnant Coloured women that abuse TIK to facilities that are equipped to treat high risk patients, such as hospitals, midwife obstetric units and day clinics. Since substance abuse treatment has not been integrated within these facilities, the problem of fragmented services has persisted for Coloured pregnant women that abuse TIK. There is thus a need to investigate how these structural barriers can be addressed in order to make possible access to effective treatment for Coloured pregnant women abusing TIK in Cape Town.

Key Words: methamphetamine, tik, pregnancy, Coloured, structural barriers, healthcare

Opsomming

Ten spyte van verskeie pogings om die struikelblokke aan te spreek wat die swanger Kleurlingvroue met 'n geskiedenis van TIK misbruik, is die tempo van toeganglikheid tot verslawings behandeling en sorg geduurende swangerskap teleurstellend laag. Onlangse artikels het die struikelblokke uit die perspektief van die swanger vroue uitgelig. Ongelukkig is daar min tot geen navorsing uit die oogpunt van die gesondheidsverskaffers om die nodige strukture in plek te sit.

Hierdie studie se doel is om die tekort aan strukture soos ondervind deur die gesondheidsverskaffers uit te lig met betrekking tot die behandeling van swanger Kleurlingvroue wat TIK misbruik. ‘n Ondersoekende kwaliteitstudie is gebruik om twintig deelnemers te identifiseer wat betrokke is by die behandeling van swanger vroue wat TIK misbruik. Semi-geskruktueerde onderhoude is gebruik om die ervare struikelblokke opteneem. Tematiese analise was toegepas om sodoende die nodige analitiese temas te genereer tydens semi-gestruktueerde onderhoude met die deelnemers.

Vanuit genoemde onderhoude is verskeie struikelblokke geïdentifiseer, naamlik: oorbelaste gesondheidsverskaffers, en swak infrastruktuur tot die beskikking van die gesondheidswerkers; die negatiewe uitwerking van die werksplek op hulle huislike lewe; uitdagings ten opsigte van behandeling buite die gesondheidswerkers se beheer; die tekort aan befondsing en swak toegeligte kommunikasie.

Bronfenbrenner (1979) se Ekologiese Stelsels Teorie was gebruik om elke tema wat die vyf vlakke van die teorie uitmaak, te konseptualiseer. Elke tema was bespreek binne ‘n interaktiewe narratief waar die mikro-, meso-, exo- en makro sisteem gekoppel was aan die huidige literatuur rondom gesondheidsverskaffers se ondervinding ten opsigte van struikelblokke wat sinvolle behandeling verhinder. Tydens die onderhoudproses was dit duidelik dat die gesondheidsverskaffers soortgelyke struikelblokke ondervind met die behandeling van pasiënte met ander gesondheidsprobleme soos HIV/Aids, tuberkulose anders dan TIK misbruik gedurende swangerskap.

Ten spyte van die feit dat dwelmmisbruik behandeling by verskeie primêre gesondheidsfasiliteite ingesluit word, ondervind die gesondheidswerkers steeds struktuele struikelblokke, naamlik : die mobilisering van swanger kleurling vroue wat TIK misbruik om

behandeling te ondergaan. ‘n Verdere bydrae is die tekort aan kundige personeel, ‘n tekort aan befondsing, asook ‘n tekort aan die nodige fasiliteite en infrastruktuur

Hoewel soortgelyke struikelblokke binne die huidige studie gelyksoortig is aan die bestaande literatuur, het unieke struikelblokke hulself gemanifesteer. As gevolg van die tekort aan regeringsbefondsing aan fasiliteite in Kaapstad, is die behandeling vir dwelmmisbruik geinkorporeer in verskeie primêre gesonheidsorgfasiliteite. Die samesmelting van hierdie gesondheidsdienste het ‘n leemte veroorsaak in die behandeling van swanger vroue wat TIK misbruik. Genoemde vroue word as hoë risiko geklassifiseer en as gevolg hiervan, kan die gesondheidsverskaffers wat werk by primêre gesondheidsfasiliteite nie vir die vroue kan behandel nie. Swanger Kleurling vroue wat TIK misbruik is dus verwys na meer ingerigte fasiliteite wat die dienste vir hoërisiko pasiënte kan verskaf.

Die gevolg hiervan is dat swanger kleurlingvroue wat TIK misbruik toegang moet kry tot fasiliteite wat wel hoë risiko pasiënte kan behandel, byvoorbeeld hospitale, vroedvrou verloskunde eenhede en dagklinieke. Alhoewel, dit is in hierdie gesondheidsfasiliteite waar dwelmmisbruik behandeling nie geintegreer is met die behandeling van swangerskappe nie. Dit veroorsaak ‘n fragmentasie in die behandeling van swanger kleurlingvroue wat TIK misbruik. Dit is baie duidelik dat hierdie struikelblokke, veroorsaak deur die fragmentasie, ondersoek moet word om sodoende effektiewe behandeling daar te stel vir swanger kleurlingvroue wat TIK misbruik in Kaapstad.

Sleutelwoorde: Metamfetamien, TIK, swangerskap, Kleurling, strukturele struikelblokke, gesondheidsorg

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List of Abbreviations

ATS - Amphetamine-Type Stimulants

BANC – Basic Antenatal Care

CAQDAS - Computer Assisted Qualitative Data Analysis Software

DoH – Department of Health

DoSD – Department of Social Development

LBW – Low Birth Weight

MOU – Midwife Obstetric Unit

PHC – Public Health Care

PME – Prenatal Methamphetamine Exposure

SANCA – South African National Council for Alcohol and Drug Abuse

SDECD – Social Development and Early Childhood Development Directorate

SGA – Small for Gestational Age

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Chapter 1: Introduction

1.1 Introduction and rationale for the present study

Methamphetamine is locally referred to as TIK in South Africa, due to the ticking sound that it makes when smoked through a 'TIK-pipe' (Oei, Bartu, Burns, Abdel-latif & Chomchai, 2011; Watt et al., 2014). TIK is a highly addictive psycho-stimulant that most often presents in the form of a white crystalline powder (Chomchai & Chomchai, 2015; Packham, 2010). The effects of TIK on the user include an increased libido and feelings of euphoria, confidence and invincibility (Chomchai & Chomchai, 2015; Watt 2014). TIK abuse amongst the general population in Cape Town is cause for concern, with a 150 times increase since 2002 (Gouse et al., 2016a). More specifically however, possibly due to increased libido and promiscuity as the side effects of TIK abuse, there has been a vast increase in the number of pregnant women abusing TIK, specifically within the coloured[1] population in Cape Town (Petersen Williams, Jordaan, Mathews, Lombard, & Parry, 2014). The high prevalence of TIK abuse amongst pregnant Coloured women has been reiterated in research that found that Coloured, single and unemployed women are at risk for TIK abuse (Petersen Williams, Jordaan, Mathews, Lombard, Parry, 2014).

Abusing TIK during pregnancy yields harmful and possibly fatal outcomes for both mother and child (Oei et al., 2011) and if left untreated, TIK abuse during pregnancy will be perpetuated in Coloured communities. Research shows that pregnant Coloured women abusing TIK in Cape Town rarely access maternal or substance abuse treatment due to the associated stigma, challenges contiguous to their pregnancy and financial difficulties (Isobell, Kamaloodien, & Savahl, 2015; Jones et al., 2011, 2014). Despite research conducted on the structural barriers to treatment experienced by Coloured pregnant women abusing TIK, studies reporting on the structural barriers as experienced by healthcare providers that are involved in the treatment of Coloured pregnant women abusing TIK have received little attention (Jones et al., 2011; McCoy, Metsch, & Chitwood, 2001; Myers, Louw, & Fakier, 2008).

Structural barriers are defined as the legal, political and environmental factors that hinder or obstruct an activity in which a person engages (Shriver, 2000). In the case of healthcare and access to treatment, Latkin (2010) states that four characteristics are found

[1] Coloured is a term used in South Africa, including on the national census, for persons of mixed race ancestry.

amongst structural level influences. Firstly, structural factors exist outside of an individual, to either nurture or hinder health. That is, even though healthcare providers treating pregnant Coloured women abusing TIK are available to offer treatment, the structural barrier of stigmatisation within their communities surrounding drug abuse during pregnancy hinders treatment-seeking behaviour in patients. Secondly, structural factors exist outside of an individual's control (Latkin, 2010). Healthcare providers who find themselves in under-staffed and under-resourced healthcare facilities are often unable to modify or change these circumstances, impeding on their ability to provide effective treatment for their patients.

Thirdly, Latkin (2010) maintains that structural factors can be either closely related to or far removed from an individual's health behaviour and outcomes. In this case, structural barriers experienced by healthcare providers that treat pregnant Coloured women abusing TIK experience these barriers on different levels. They may experiences problems within consultation or on an individual level where appropriate medical equipment is unavailable or healthcare providers could experience structural barriers on a larger lever where they experience burnout due to under-staffing. Lastly, structural factors are more often far removed from an individual's behaviour, and exist in a continuum of various causes of behaviour. Structural factors are therefore classified as having remote influence over and cause of health behaviour (Latkin, 2010; Levy, 2015). The existence of structural barriers on a continuum of causes leading to behaviour is what makes these barriers difficult to address. In Latkin (2010) and related literature, examples of structural barriers obstructing treatment and healthcare are noted as a poverty amongst patients, shortage of government funding and resources, insufficient qualified personnel, low service quality and a lack of comprehensive services (Jones et al., 2011; Myers et al., 2008; Xu, Wang, Rapp, & Carlson 2007).

In Cape Town, the high prevalence of TIK abuse amongst coloured pregnant females is met with a paucity of in-patient, government funded treatment facilities (Harris, Eyles, Penn-kekana, Thomas, & Goudge, 2014; Myers et al., 2008; Puljevi & Learmonth, 2014). Currently, there is only one government-funded female inpatient treatment facility in Cape Town to service the entire Western Cape (Fritz, 2016). Treating a maximum of 40 patients at a time, those women who apply for but cannot access this treatment centre are forced to seek substance abuse treatment within outpatient facilities. These facilities are often far distances from the services that can provide maternal treatment which structural barriers such as

unaffordable transport, exacerbate lack of treatment access (Coetzee, Kagee, & Vermeulen, 2011; Smith, Easter, Pollock, Pope, & Wisdom, 2013).

In order to provide comprehensive treatment to the joint problem of maternal treatment and substance abuse, the ideal scenario would be to have both forms of healthcare simultaneously available in one healthcare facility. However, structural barriers such as a lack of funding and resources, prevents this kind of care. The difficulty of accessing treatment for pregnant coloured women abusing TIK thus contributes to the maintenance of TIK abuse during pregnancy, placing both mother and child at risk of physical and psychological harm (Gorman, Orme, Nguyen, Kent, & Caughey, 2014; Kwiatkowski, Roos, Stein, Thomas, & Donald, 2014; Onah, Field, van Heyningen, & Honikman, 2016). Additionally, it could lead to wider social repercussions including domestic violence and involvement in gangsterism for the future generation of Cape Town (Calix, 2013; Carroll & Onken, 2005; Clark, 1995).

Acknowledgement of TIK abuse amongst pregnant Coloured women in Cape Town as a social evil is a vital part of addressing this problem in the Cape Town community. Exploring healthcare providers' concerns and experiences of the structural barriers to the treatment of pregnant Coloured women abusing TIK, offers a complimentary voice in ensuring a more balanced understanding of the health challenges related to TIK and Coloured pregnant women. The relevance of uncovering these structural barriers within the South African healthcare system may help to make the treatment of pregnant Coloured women abusing TIK more accessible and effective. This study aims to uncover the healthcare provider's perspective of the structural barriers that are problematic in delivering effective healthcare to Coloured pregnant women abusing TIK. This investigation of the structural barriers experienced by the healthcare providers treating pregnant coloured women abusing TIK is intended to provide insights that could potentially contribute to the formulation of methods to address these barriers.

1.2 Key Terms and Definitions

1.2.1 TIK

TIK is the local South African name used to refer to methamphetamine. TIK (methamphetamine) is a psycho-stimulant that induces feelings of confidence, euphoria and a heightened libido within users (Geldenhuys, 2015; Plüddeman, Myers, & Parry, 2008; Watt et al., 2014). It is most commonly used in the form of a white powder, smoked through a

'TIK pipe' (Chomchai & Chomchai, 2015). Since the participants of this study all reside in Cape Town and refer to methamphetamine as TIK, it was decided that the local terminology for methamphetamine would be used in the presentation of this study.

1.2.2 Coloured

During the Apartheid period in South Africa, citizens were segregated on the basis of race. The term 'coloured' was used to refer to those citizens of mixed racial ancestry (black and white ancestry) and who are mainly Afrikaans speaking (Calix, 2013; Larkin, 2015; Oei et al., 2011).

1.2.3 Healthcare

Healthcare is defined as the service provided to individuals by healthcare providers in order to promote, maintain, monitor and restore health (World Health Organization, 2004).

1.2.4 Healthcare provider

The World Health Organization (2004) defines a healthcare provider as an individual professional, group or institution that delivers healthcare services. In the context of this study, healthcare providers consist of nurses[2], midwives, social workers, psychologists, counsellors and psychiatrists.

1.2.5 Access to treatment/healthcare

Access to treatment and healthcare is described as the ability of an individual or population to receive or obtain treatment or healthcare (World Health Organization, 2004). This includes programme and service availability, as well as the availability of facilities and records (World Health Organization, 2004).

1.2.6 Structural Barrier

Structural barriers consist of legal, political and environmental factors that act as barriers to the actions in which people engage (Shriver, Everett, & Morin, 2000). In the context of the present study, structural barriers emerge in the form of staff shortages, lack of funding and unavailability of treatment facilities.

[2] Where nurses and midwives are referred to throughout this study, it is by no means gender-biased and refers to this profession in both male and female capacities.

1.2.7 Treatment

Specific to the context of this study, treatment refers to the provision or receiving of care on both a maternal and substance abuse platform. The World Health Organization (2004) defines treatment as the management and care of a patient to combat disease or disorder.

1.2.8 Inpatient treatment

Inpatient treatment is provided to an individual that has been admitted to a hospital or to another facility for diagnosis and/or treatment. Inpatient treatment is characterised by at least an overnight stay (World Health Organization, 2004).

1.2.9 Outpatient treatment

Outpatient treatment is defined by the World Health Organization (2004) as treatment received without being admitted to a facility. The nature of the treatment is thus defined as ambulatory, which refers to the patient travelling to the facility and receiving treatment with no overnight stay (World Health Organization, 2004).

1.3 Outline of the Research Project

Chapter two will provide a systematic literature review in relation to the experiences of healthcare providers that encounter structural barriers that hinder effective treatment of pregnant coloured women who abuse TIK. This includes a brief history of South Africa, the healthcare system during and post-Apartheid and the prevalence of TIK abuse and its effects on the neonate. To follow, will be a review of structural barriers experienced by healthcare providers who treat individuals with other disorders, and a description of why comprehensive healthcare is necessary. Chapter 2 will conclude with a description of the theoretical framework that was used to contextualise and interpret the findings of this study.

Chapter three provides an in-depth description of the methodology used to complete the present study. It includes the rationale, the research questions and the aims and objectives of the present study. Furthermore, a description of the research design, the participants and the sampling and the data collection methods will be provided. The six steps of thematic analysis used to analyse the data will be discussed, as well as the vital steps taken to ensure trustworthiness. The chapter will conclude with the ethical considerations that were pertinent to the study.

Chapter four provides the results and core findings that were obtained during the execution of this study. This chapter presents the key themes and sub-themes highlighted by a thematic analysis of the semi-structured interviews conducted with the participants in this study.

Chapter five engages with the core findings of this study in relation to current literature surrounding the topic of this study. Furthermore, the theoretical framework used to contextualise these themes, namely Bronfenbrenner's (1979) Ecological Systems Theory, is also incorporated into the fifth chapter. To conclude the chapter, the present study's limitations will be provided, as well as recommendations for future research.

Chapter 2: Literature Review

In this chapter, current literature will be reviewed in relation to the structural barriers to treatment that healthcare providers experience when treating pregnant coloured women who abuse TIK. The literature review will be arranged by providing context for the problem of TIK abuse during pregnancy within the coloured community and associated structural barriers to treatment. To begin, a brief overview of South African history will be given to contextualise the nature of the South African healthcare system during the Apartheid period. Thereafter, the current healthcare system will be contextualised within the post-Apartheid period. Furthermore, the prevalence and effects of TIK abuse will be discussed followed by a review of the current structural barriers that healthcare providers experience when treating pregnant women with substance abuse disorders. The chapter will then be concluded by describing the theoretical framework that informed the interpretation of the findings of this study.

2.1 South African history

During the Apartheid era, from 1948 – 1994, the National Party enforced segregation laws, separating facilities, such as education and medical care, based upon race (Maylam, 1995). Under the Bantu Education Act, Act 47 of 1953, non-white citizens[3] received a specifically tailored education that was created to equip them only with skills that were regarded as useful for serving their own people. The reason for this was to ensure that non-white people were not educated for positions that they would never fill (Maylam, 1995; Myers, 2007). In 1959, non-whites were allocated separately defined geographical regions to which they were subsequently relocated (Cooper et al., 2004). A selected Commissioner-General was tasked with forming a government for each non-white community. This was the National Party's attempt to remove non-whites from South African society (Legassick, 1974). The removal of South African citizenship from non-white citizens was subsequently realised with the Bantu Homelands Citizens Act of 1970 which forced non-whites to relocate and become citizens of the defined region (referred to as 'homelands') allocated to their ethnic group (Cooper et al., 2004; Coovadia, Jewkes, Barron, Sanders, & McIntyre, 2009; Legassick, 1974). Coloured and black people were forced to live in homelands with little or no access to social resources (Andersson & Marks, 1988). As a result, non-white homelands

[3] Non-white, in this study, refers to all people who are not of white descent including African, Coloured (mixed-race) and Indian.

were poverty-stricken and crime-ridden and had minimal access to healthcare services (Myers & Parry, 2005; Myers et al., 2008).

2.1.1 South African public healthcare during the Apartheid Era

The segregation of access to healthcare in South Africa culminated in the structural inequity of the Apartheid health system (Gray, 2015). Upon implementation of the Homeland Citizens Act (1970), healthcare systems were developed within each homeland allocated to the various ethnic groups (Myer & Harrison, 2003). This resulted in 14 different health departments, each with its own authority, administration and access to resources (Cooper et al., 2004; Coovadia et al, 2009; Gray, 2015). The majority of the resources were allocated to healthcare delivery to white communities in urban areas and were focused on curative hospital-based care (Cooper et al., 2004; Gray, 2015). Minimal priority was given to healthcare provision at the Primary Healthcare (PHC) level that focused on the health promotion and disease prevention at a local level (Gray, 2015). Healthcare in non-white communities was thus structured around under-resourced PHC and hospital services which underserved the communities within which they operated (Gray, 2015). During the 1970's, the doctor to patient ratio was 1:15,000 in non-white areas compared to 1:1,700 in white areas (Coovadia et al., 2009). The private health sector increasingly extracted services from the public health sector and by 1980, the difference in per capita funding between public (non-white) and private (white) healthcare was tenfold (Gray, 2015).

Regarding healthcare for non-white pregnant women, no comprehensive reproductive health policies existed during the Apartheid era (Coovadia et al., 2009). The focus on non-white women's healthcare services was on the implementation of contraceptive services in order to curb non-white population growth (Cooper et al., 2004). In comparison to the 65,000 contraceptive sites created, the scarce maternal services offered were poorly developed, overcrowded, understaffed and largely inaccessible to the majority of the non-white population (Cooper et al., 2004; Meer, 1984).

Specifically in coloured communities, the ratio of nurses to patients in these facilities were 1:549 coloured patients and the ratio of doctors to coloured patients was 1:1200 (Meer, 1984). Short staffing within maternal facilities offering maternal treatment resulted in long waiting periods and diminished treatment efficacy (Harris et al., 2014; Myers et al., 2008).

Furthermore, deteriorating infrastructure and scarce resources made the effective treatment of pregnant coloured women improbable (Amnesty International, 2014).

2.1.2 The fall of the Apartheid government

During the 1980's, as the non-white members of the South African nation began to gain power, the Apartheid government, in fear of losing power, heightened security and initiated armed patrols in non-white areas (Andersson & Marks, 1988). Violence and maltreatment in South Africa had become the norm, resulting in devastating physical and mental outcomes for non-white communities (Andersson & Marks, 1988). Specifically, the physical and mental health of the Coloured community in South Africa was gravely affected by what is internationally known as the DOP system (Crome & Glass, 2000). The DOP system is explained by Gossage et al. (2014), as partial or full payment in the form of food and wine that coloured farm workers received for their labour instead of wages. DOP is the Afrikaans word for 'tot' and within the DOP system, it has been recorded that wine was given to workers up to five times a day (Gossage et al., 2014). In their study conducted on the DOP system and the social exclusion of the coloured community, Crome & Glass (2000), found that this system has had a catastrophic effect on the coloured community and its identity. They state that the DOP system has been associated with the reality and stigma of problem drinking and associated substance abuse from the 1980's until today in Post-Apartheid South Africa (Crome & Glass, 2000; Larkin, 2015).

Additionally, the Apartheid government's laws rendered the traditional facets of manhood virtually unachievable for coloured and black men (Coovadia et al., 2009). The resort to gangsterism amongst coloured males was a result of their inability to attain the necessary financial success to fulfil a provider role. The adaptation of the idea of manhood and the generation of income was thus initiated through the strength and camaraderie found within gang culture (Coovadia et al., 2009). The Apartheid regime is often cited as the catalyst for today's notorious 26, 27 and 28's gangs in Cape Town (Macmaster, 2007; van Wyk & Theron, 2005; Wood, 2016).

In 1994, when South Africa was declared a democratic nation, policies focusing on redress and equality were put into place (Maylam, 1995; Thusi, 2013). The Bill of Rights established in 1996, the Batho Pele Principles (People First) introduced in 1997, the Patients' Health Charter and the National Health Act of2003, were established for those people

adversely affected by the Apartheid regime. These policies prescribe the rights and responsibilities of healthcare providers and patients and contextualize the health care system in post-Apartheid South Africa (Harris et al., 2014; Rispel, 2015). For example, free healthcare for women and children should be provided within the redressed health system (Rispel, 2015). However, these policies that were put into place for the equal redistribution of healthcare appeared only at face value to be successful in effectively turning the South African health system around. South African citizens' constitutional right to healthcare is promised, but structural barriers hinder access to this healthcare and thus the barriers faced by non-white communities during the Apartheid era are maintained (Myers, 2007).

2.1.3 Post-Apartheid South African public healthcare

The ANC published its National Health Plan for South Africa in 1994, with strategies to create a unified public health system based upon a PHC service approach (Gray, 2015). Under Article 27 of the South African Constitution, the right to accessible healthcare declares that health facilities, goods and services must be physically, economically and socially acceptable and accessible to all and be free from discrimination. Health facilities must be within safe physical reach and they must be affordable for everyone, especially marginalized groups (Amnesty International, 2014). In the 22 years since the introduction of the National Health Plan, healthcare provision in Post-Apartheid South Africa still finds itself challenged with staff shortages, unsupportive and poor management structures, infrastructural challenges and funding and resource deficiencies (Gray, 2015; Myers et al., 2008; Rispel, 2015). Unable to provide quality health care, healthcare providers are confronted with women who have minimal or no education, little awareness of the associated harms of using illegal substances and desperation for an escape from the trauma and poverty inflicted by the Apartheid system (Myers, Louw, & Pasche, 2010; Myers, 2007). The results for these healthcare providers are low treatment retention, poor treatment efficacy, frustration, burnout and low job satisfaction (Myers et al., 2008). The inaccessibility of effective treatment services has allowed drug abuse and drug abuse during pregnancy in South Africa and specifically in coloured communities in the Cape Town area, to develop into an uncontrollable crisis in which TIK is the drug of choice (Jones et al., 2011; Myers & Parry, 2005; Myers et al., 2010; Myers et al., 2008; Plüddemann, Myers, & Parry, 2008).

2.2 Prevalence of TIK abuse

With 24 million users worldwide, TIK (methamphetamine) abuse has become a global epidemic (Chomchai & Chomchai, 2015). Its unparalleled rate of production and trafficking across the globe has accounted for almost 71% of seizures that result from the abuse of amphetamine-type stimulants (ATS) all over the world (Chomchai & Chomchai, 2015). In South Africa, TIK abuse poses a problem, with 22.9% of South Africans reporting regular use of the drug (United Nations Office on Drugs and Crime, 2015). TIK is most prevalent however, in the Western Cape, which has the highest concentration of TIK abuse in the world with 37% of users reporting TIK as their primary substance of abuse (Dada et al., 2016).

With the fall of the Apartheid government in 1994 and international reinvestment in South Africa, increases in exports and trade were met with a decline in border security and control (Goga, 2014; Plüddeman, Myers, Parry, 2008). With the loosening of the once tight security measures, the country's borders became vulnerable to the entrance of illegal substances (Myers et al., 2008). As these substances made their way into the country, drug abuse began to rise. Countless citizens became addicted to illegal substances, which resulted in higher demands for under-resourced healthcare delivery (Goga, 2014; Myers & Parry, 2005). Of all people seeking healthcare, the prevalence of substance abuse among coloured pregnant females became alarmingly common in and around the Cape Town area (Jones et al., 2011, 2014; Myers et al., 2010; Myers et al., 2008). Professor Johan Smith, the head of the neonatology department at Tygerberg Hospital, reported that within this hospital alone, 10 babies are born every day to mothers who abuse TIK (Geldenhuys, 2015). Furthermore, he notes that only 6% of mothers who give birth in the Western Cape, confess to their TIK abuse during pregnancy (Geldenhuys, 2015). In 2015, approximately 70 000 babies were born in Cape Town alone (Statistics South Africa, 2015). This means that of these babies, at least 4200 have prenatal exposure to TIK (Geldenhuys, 2015).

2.3 Effects of TIK abuse

TIK is a highly addictive psycho-stimulant that affects the central nervous system (Goga, 2014; National Institute on Drug Abuse, 2015). It most often is used in the form of a white crystalline powder, that is smoked using what is locally known as a 'TIK pipe' or 'straw' (Chomchai & Chomchai, 2015; Dada et al., 2016). TIK is considered a cheap drug with one 'straw' being bought for between R15 and R30. Goga (2014), reports that the ease of manufacturing TIK is what has caused its wide accessibility.

Its affordability and wide availability makes TIK attractive to its users (Goga, 2014). Reported effects of TIK include increased confidence and a heightened libido causing unsafe sexual activity (Carroll & Onken, 2005; Plüddeman et al., 2008). TIK abuse amongst young coloured females has increased due to the belief that the drug has weight loss properties and provides abundant energy (Plüddeman et al., 2008). As a result of the side effects of TIK, many young coloured women abusing this drug find themselves pregnant and unable to discontinue their TIK abuse. Although the women who discover that they are pregnant may attempt to reduce their TIK usage, its addictive nature makes it difficult to do so without treatment (Myers et al., 2014). Pregnant coloured women abusing TIK thus continue or increase their abuse of the drug and subsequently fail to seek and access treatment (Jones et al., 2011).

If a pregnant woman is not treated for her TIK addiction and/or does not receive the appropriate prenatal care, the consequences for her and her child can be fatal (Bartu et al., 2011; Jones et al., 2011; Williams et al., 2014). While the outcome of long term TIK abuse on an adult brain has been widely documented, recording the interrupted neurological development and damage to an unborn baby has proven difficult. Of the dangers cited, TIK has been found to penetrate the placenta and pass through the blood-brain barrier. This results in restricted blood flow through the placenta to the foetus (Gorman et al., 2014; Kwiatkowski et al, 2014; Ladhani, Shah, & Murphy, 2011; Wouldes et al., 2014). New-borns with PME (Prenatal Methamphetamine Exposure) have been found to be born prematurely, are small for gestational age (SGA) and have a low birth weight (LBW) (Jones et al., 2014; Kwiatkowski et al., 2014; Ladhani et al., 2011; Wouldes et al., 2014).

Exposure to TIK abuse during the gestational period increases the chance of maternal complications and contributes to unfavourable physical, psychological, behavioural and social sequelae (Abar et al., 2014; Bartu et al., 2011; Gorman et al., 2014; Kwiatkowski et al., 2014; Wouldes et al., 2014). Documenting the implications of PME, the IDEAL (Infant Development, Environment and Lifestyle) study, conducted in New Zealand and the USA found that the rate of physical development and growth of children who had PME within the first three years of life, was significantly low (Wouldes et al., 2014). Furthermore, during adolescence, methamphetamine-exposed children present with heightened aggression and violence as well as antisocial and delinquent behaviour (Abar et al., 2014).

Children with PME who live in coloured communities in Cape Town that are rife with poverty, drug syndicates and drug abuse are likely to perpetuate the cycle of TIK abuse (Kwiatkowski et al., 2014). Furthermore, with a high prevalence of PME and TIK abuse in the coloured community, aggressive and behaviourally unpredictable adolescents will perpetuate the cycle of gangsterism, domestic and community violence and crime (Calix, 2013; Carroll & Onken, 2005; Kwiatkowski et al., 2014). Thus, the immediate ramifications for mother and child are not where the consequences of TIK abuse during pregnancy cease. The effects of TIK abuse during pregnancy have far-reaching social implications and have the ability to exacerbate the challenging social issues within coloured communities in particular. The far-reaching social implications of TIK abuse during pregnancy are not within the scope of this study. However, the dire need for treatment for coloured women abusing TIK during pregnancy is noted.

The healthcare providers that are available to treat pregnant coloured women abusing TIK encounter many difficulties that hinder their ability to provide effective treatment. By highlighting the structural barriers that obstruct the treatment of pregnant coloured women abusing TIK, the resulting findings could potentially contribute to the development of effective treatment strategies. In order to highlight structural barriers, the experiences and frustrations of healthcare providers are documented in the next section.

2.4 Healthcare providers and structural barriers

The healthcare providers participating in this study are individuals that are employed in the profession of healthcare delivery. This includes nurses, midwives, social workers, psychologists, counsellors and psychiatrists that are, or have been involved in the treatment and recovery process of coloured females who are abusing or have abused TIK while pregnant.

The barriers to treatment experienced by pregnant coloured women who abuse substances have been widely documented (Puljevi & Learmonth, 2014; Wechsberg, Luseno, & Ellerson, 2008). Wechsberg, Luseno, & Ellerson (2008) found in their study on stigma around substance abuse amongst pregnant females, that these women have complex and specific needs upon entry into and during treatment. Pregnant women abusing substances are often diagnosed with comorbid conditions such as depression and anxiety disorders and often

present for treatment with low self-efficacy due to shame of substance abuse addiction and powerlessness in their situation of poverty (Wechsberg et al., 2008).

Similarly, Jessup et al. (2003) found that extrinsic barriers such as stigma and racism can negatively affect treatment seeking behaviour amongst substance abusing pregnant women. In the South African context, pregnant coloured women seeking substance abuse treatment are burdened with previously disadvantaged living conditions of poverty, trauma, history of sexual abuse, lack of education; unemployment and exposure to domestic violence (Bartu et al., 2011; Jessup et al., 2003; Jones et al., 2011; Lutchman, 2008; United Nations, 2004; Terplan & Smith, 2009; Wechsberg et al., 2008). The focus of this study, however, is on the structural barriers to treatment that healthcare providers experience when treating these women.

2.4.1. Structural barriers experienced by healthcare providers

The sensitive nature of South Africa's history of segregation and violence has created a platform for healthcare reform. The South African public healthcare system has been renovated to include integrated healthcare with a strong focus on PHC (Cooper et al., 2004; Coovadia et al., 2009). More specifically, South African reproductive health policies have a strong focus on sexual and reproductive rights regarding maternal health, abortion, gender-based and sexual violence and AIDS (Cooper et al., 2004). However, access to the reformed healthcare system is neither automatic, nor guaranteed. Structural barriers hinder both access to, and delivery of, effective treatment (Harris et al., 2014). In their study examining access barriers to the post-Apartheid healthcare system, Harris et al. (2014) found that an under-resourced, hierarchical health system can create a setting in which access to healthcare is problematic. Similarly, in their study on removing structural barriers to healthcare for historically disadvantaged communities, Myers, Louw, & Fakier, (2008) noted three chief structural barriers to effective service delivery. The first is limited collaboration and communication between the government and healthcare providers that results in misguided healthcare strategies. The second is the limited allocation and availability of resources that have restricted the availability of services rendered. Lastly, Myers et al. (2008) noted the problem of fragmented service delivery.

2.4.1.1 Government-funded service delivery

The poor communication between government departments that deal with substance abuse and healthcare, namely, the departments of health (DoH), education (DoE) and social development (DoSD), has led to misinformed prevention intervention strategies (Myers et al., 2008). Healthcare providers have recorded the lack of communication as a chief barrier to the state provision and even allocation of resources to treatment centres (Myers et al., 2008). Such resources include medication, staff and equipment (Myers et al., 2008). With poor communication between healthcare providers in the field and their respective government departments, allocation of funding and resources are not informed by each facility's needs but rather by only a basic understanding of the problem of substance abuse (Geach, 2015).

Government departments are often not led by members who have specialised knowledge and experience in the field that they are assigned to address, thus making communication with healthcare providers in the field a vital step in the strategy planning process. The current president of the DoSD, Bathabile Dlamini, who has been placed at the forefront of taking control of substance abuse in South Africa, is specialised in the field of domestic violence and petitioning against violence against women (www.dsd.gov.za, 2015). More specifically, the members of the Western Cape DoSD that are leading the substance abuse programme, are educated as social workers and are not necessarily specialised in the field of substance abuse (www.dsd.gov.za, 2015).

Healthcare providers report that their experience with government officials regarding the implementation of strategic plans for substance abuse treatment shows that these officials do not have the necessary specialised knowledge to make decisions to drive effective treatment processes (Myers et al., 2008). The DoSD's lack of collaboration and consultation with the healthcare providers in the field results in a misconception of the full extent of the problem of substance abuse among pregnant coloured women in Cape Town. Government officials, with only a basic understanding of the problem, cannot appropriately respond to the needs of the community and the healthcare providers delivering treatment. Healthcare providers thus report that although plans to address the problem of TIK abuse among pregnant coloured women have been established, nothing has been implemented on a ground level (Myers et al., 2008).

The issue of communication between healthcare providers in the field and government officials, was addressed in the Alcohol and Other Drugs (AOD) strategy 2014-2017 (City of Cape Town, 2014). In response to the shortcomings of the previous strategy in 2011, the latest AOD strategy includes the collaboration with stake holders in the intervention process in order to facilitate coordination between healthcare providers in the field and government officials (City of Cape Town, 2014). Similarly in his 2016 budget speech for the DoH, the Western Cape Minister of Health, Dr Nomafrench Mbombo (2016) noted that decisions regarding budget allocation and the appointing of staff will be made by healthcare facility managers who are in the field and understand the needs unique to their facility and community.

The Western Cape DoH minister's response to the problem of communication between healthcare providers and those members of government who make the relevant decisions is commendable (Mbombo, 2016). The successful implementation of the latest AOD strategy however, has yet to be determined. Decisions made by facility managers regarding funding allocation and staff employment continue to be negatively affected by the structural barrier of the shortage of funding received from government departments.

2.4.1.2 Financial restrictions and limited availability of resources

With the aim of creating new healthcare centres, improving hospitals and adding to healthcare training programs, roughly R31 billion was allocated to public healthcare in South Africa for 2015/16 (The World Bank Group, 2014). Approximately 85% of South Africa's population make use of the public healthcare system. Resources are stretched thin when only 56% of all healthcare expenditure is allocated to the public health sector (Harris et al., 2014; Kahn, 2014).

During Pravin Gordhan's revised National Budget Speech in February of 2016, he noted that R213.3 million will be allocated to substance abuse treatment and substance abuse treatment centres in South Africa for 2015/16 (National Treasury, 2016). According to the Prevention of and Treatment for Substance Abuse Act (2008), at least one substance abuse treatment centre must be available in every province (National Treasury, 2016). With 4 provinces currently retaining seven treatment centres, an additional R166 million was allocated to the development of substance abuse treatment centres in the Eastern Cape, Northern Cape, North West and the Free State (National Treasury, 2016). Although the extra

funding allocated to the development of facilities within these provinces is appropriate, it may serve as one of the reasons for the lack of funding to current substance abuse treatment centres in Cape Town.

There are currently 5 government funded inpatient substance abuse treatment centres in the Cape Town area, only one of which is a fully government-funded, female-only treatment facility (Mbombo, 2016). As of June 2016, the only inpatient government-funded female facility became fully DoSD funded. This facility can accommodate 40 women at one time. However, compared to the rising prevalence of pregnant coloured women abusing TIK, as discussed earlier in the chapter, one treatment facility is clearly insufficient to address the demand for treatment.

The tension between the paucity of financial provision from the state and the need for treatment facilities for pregnant coloured women abusing TIK has placed healthcare providers in a difficult position. Pregnant coloured women abusing TIK (and other substances) are turned away from inpatient facilities as these facilities do not have the resources to treat pregnant women (United Nations Office on Drugs and Crime, 2004). Similarly, non-pregnant women abusing TIK who are seeking substance abuse treatment can wait up to 6 months to gain access to the inpatient treatment facility (Isobell et al., 2015; Myers et al., 2010; Scheppers, 2006). In a study conducted by Isobell et al. (2015) on the perceptions of referring agents for inpatient substance abuse treatment centres within the Western Cape, participants note that the most prominent problem for accessing inpatient facilities is that there are no facilities available to access. Furthermore, the participants stated that more government-funded treatment facilities that are evenly distributed are critical for access to, and the improvement of substance abuse service delivery.

Historically, substance abuse has largely been thought of as a mental health problem to be treated by specialised facilities (Ernst, Miller, & Rollnick, 2007). Substance abuse disorder was subsequently not provided for within primary health care, rendering it inaccessible to those who cannot afford specialised services. In 2008, in an attempt to address the problem of access to substance abuse treatment services, the City of Cape Town incorporated substance abuse treatment into primary healthcare facilities (Gouse et al., 2016a; Pascoe, 2010).

The Matrix model, which is part of the Integrated Substance Abuse Programmes (ISAP) at the University of California, is an intensive evidence-based outpatient approach to the treatment of substance abuse (Gouse et al., 2016b). It includes a 16 week cognitive-behavioural treatment method that includes individual, group and family therapy. Although widely tested in parts of the USA, there is little evidence of the efficacy of the Matrix model in South Africa (Gouse et al., 2016b). In their study on the effectiveness of the first Matrix model implemented in an under-resourced community clinic in Cape Town, Gouse et al. (2016b) found numerous challenges regarding treatment initiation and retention. These authors noted that gang-related factors, lack of child-care, transport-related challenges and difficulties with referral were experienced as barriers to treatment by both the patients and healthcare providers (Gouse et al., 2016b). Furthermore, issues relating to motivation for treatment were also recorded as barriers to treatment retention (Gouse et al., 2016a).

The implementation of substance abuse treatment within PHC clinics has yielded promising successes in the reduction of substance abuse and has increased access to both substance abuse treatment and healthcare in the respective communities (Gouse et al., 2016a). This seems to have alleviated the shortage of funding for creating more in-patient substance abuse treatment centres in Cape Town. However, healthcare providers within these out-patient treatment centres, such as Matrix Clinics and South African National Council for Alcoholism and Drug Dependence (SANCA) offices, continue to experience structural barriers to treatment regarding pregnant coloured women abusing TIK. The effort to make substance abuse treatment more accessible is strong; however, the shortage of funding has created the challenges of limited staff and resources and poorer service quality(Myers et al., 2008).

2.4.1.3 Limited availability of staff and resources and poor quality of service delivery

Of the R350 billion healthcare budget, 7,8% is allocated to the training of healthcare professionals such as nurses and midwives (National Treasury, 2016). The large sum of funding devoted to training more healthcare personnel is indicative of the shortage of staff in the public healthcare sector. Rispel (2015) has found in her research on health system deficiencies in South Africa, that 20 years into democracy, there are still funding and capacity problems within the South African public healthcare system. She states that healthcare

providers are in the forefront of this deficiency and as a result, struggle to uphold the provision of good quality treatment (Rispel, 2015).

Even with the 2014-2017 amended AOD strategy of placing staff employment in the hands of the facility managers, facilities remain understaffed due to a shortage of funding. Tight budgets allocated by government to treatment centres only allow for a limited number of personnel to be employed and placed on the state payroll (Gray, 2015). Thus, treatment centres remain overwhelmed with high volumes of patients that are in need of healthcare (Meerkotter, Geffen, & Petoors, 2015; Rispel, 2015; Thorsen, Tharp, & Meguid, 2011). In a study conducted in the USA, it was debated through legal channels whether or not staff shortages impinged on the constitutional rights of those seeking treatment and those already in treatment (Way, Braff, Hafemeister, & Banks, 1992). Considering South African history and its gross impingements on human rights, this is an interesting avenue to consider when evaluating the South African healthcare system and access to it.

Staff shortages create the platform for burnout and ill-treatment of patients among healthcare providers, negatively affecting service delivery (Mkhwanazi, 2012). Furthermore, staff shortages create the problem of long waiting periods before treatment is received (Myers et al., 2008). Daniels (2015) conducted an assessment on the usefulness of information gathered during a waiting time survey, in formulating methods for reducing waiting times in primary care clinics in Cape Town. He found that long waiting times diminish motivation for treatment among patients, decrease the perceived quality of care and prove to be expensive for patients who could be earning money during the time they spend waiting for treatment. From a healthcare providers' perspective, Reagon & Igumbor (2008) found that the reason for long waiting times is that facilities are short staffed and that healthcare providers are grossly overburdened. Additionally, Daniels (2015) found similar structural barriers causing long waiting times, such as bottlenecking due to the arrival of large batches of patients at once (usually to be at the front of the queue), queue management problems and infrastructural challenges such as insufficient space and equipment shortages.

On both platforms of maternal and substance abuse, waiting time presents as a structural barrier to effective treatment. In their analysis of the substance abuse treatment provided within primary healthcare in New Mexico, Ernst, Miller, & Rollnick (2007) found that although the integration of the two was smooth and accessibility was increased, long waiting lists characterised these programs. Similarly, in South Africa, the same problem

arises. Myers (2007) found, in her study on access to alcohol and drug treatment for people from historically disadvantaged communities in the Cape Town Metropole, that waiting times pose a threat to the access to and efficacy of treatment. Substance abusing individuals, by nature, do not have the patience to sit and wait for treatment as most of them are hesitant about seeking treatment to begin with (Redko,Rapp, & Carlson, 2006). With this, their so called 'therapeutic window of opportunity' is missed (Myers et al., 2008). The 'therapeutic window of opportunity' is defined as an opportune period for early intervention to take place in order to prevent the worst circumstances from occurring (Myers et al., 2008). Overburdened healthcare providers are unable to immediately treat patients that are in need, thus, the 'therapeutic window of opportunity' is missed and TIK abuse is likely to continue.

The overburdening of healthcare providers owing to staff shortages also culminates in high staff turnover (Myers et al., 2008). For those employed in government funded treatment centres, salaries are small (McCoy et al., 2008). Midwives and nurses earn between R5,000-R10,500 per month before tax deductions (Deparment of Public Service and Administration, 2014). Similarly, substance abuse healthcare providers within the public health sector earn roughly R12,500 per month before tax deductions (Deparment of Public Service and Administration, 2014). Making personal ends meet with a small salary as remuneration for the type of demanding and overburdened service that healthcare providers deliver, has been found to cause frustration and low job satisfaction, which in turn causes tension within the home as well as the workplace (McCoy et al., 2008). Furthermore, healthcare providers question whether their best efforts are worth the hardship of attempting to treat so many patients with so few resources (McCoy et al., 2008; Myers et al., 2008). As a result, high staff turnover has been documented amongst both maternal and substance abuse healthcare providers (Coetzee et al., 2011; Hayes et al., 2004; McCoy et al., 2008; Myers et al., 2008).

Staff turnover appears to be a structural barrier in its own right. Healthcare workers report training new staff for 2 to 3 years and then losing them to private clinics or positions abroad, where salaries are much higher (Myers et al., 2008). The healthcare workers that remain within public health clinics are left with unfilled positions and thus find themselves completing administration and human resource tasks that have nothing to do with substance abuse or maternal treatment (Myers et al., 2008). Likewise, it is under these conditions that staff experience overburdening, frustration and burnout running full circle and perpetuating high staff turnover (Myers et al., 2008).

2.4.1.4 Fragmented service delivery

Pregnant coloured women abusing TIK will inevitably be referred for additional treatment on the basis of either their pregnancy or their substance abuse (Isobell et al., 2015). Maternal healthcare providers see to the physical and obstetric needs of patients. This includes prenatal checks every four weeks to make sure the foetus is healthy with no defects (World Health Organization, 2002). Maternal staff will, as part of an overall antenatal assessment, make use of questions to highlight the psychological health of a mother. If it is determined that the psychological health of the mother is not what it should be, the necessity for additional services, to which the patient will be referred will be indicated (World Health Organization, 2002). On the other hand, substance abuse healthcare providers attend to the psychological needs of patients for their substance abuse and trauma related to substance abuse. Coupled with the paucity of female in-patient facilities in Cape Town that provide both substance abuse and maternal treatment, women are forced to seek treatment from more than one facility. Ordean & Kahan (2011) conducted a study on a comprehensive treatment program for pregnant substance users in a family medicine clinic in Canada. Their participants reported that before access to the comprehensive program, they were required to access maternal and substance abuse treatment within different facilities. The fragmentation of these services resulted in poor treatment compliance due to financial and social support limitations (Ordean & Kahan, 2011). Furthermore, little communication occurred between the two treatment sites.

Similarly, the United Nations Office on Drugs and Crime (UNODC)(2004) review of substance abuse treatment and care for women, noted that the three most prominent strategies to be incorporated into amended treatment was that of early detection; establishing women-only programmes and integrating fragmented services. As mentioned in section 2.3.1.2, the City of Cape Town has implemented a program that amalgamates healthcare and substance abuse treatment by incorporating the Matrix model for substance abuse into PHC facilities in Cape Town. However, the rate of pregnant coloured women accessing substance abuse treatment at PHC facilities remains low (Gouse et al., 2016a). The rate of pregnant coloured women accessing substance abuse treatment at any available facility, in-patient or out-patient, also remains low.

2.5 Why comprehensive care in one facility?

The social and financial ramifications of substance abuse among pregnant coloured women in South Africa can be seen in high child and maternal mortality rates as well as the high cost of substance abuse related crime (Jones et al., 2011; Plüddeman et al., 2008). Bearing in mind the future generation of South Africa, comprehensive healthcare and its promising outcomes for maternal and child health should be earnestly considered. According to various studies, comprehensive care, which effectively treats substance abuse during pregnancy across all facets, ends up costing a country less financially and socially than dealing with the outcomes of untreated substance abuse and substance abuse during pregnancy (Ashley, Marsden, & Brady, 2003; Clark, 1995; Jones et al., 2014; Myers et al., 2008; Ordean & Kahan, 2011).

In their discussion paper, Hawkins et al., (2015) compared the cost of crimes related to substance abuse to the cost of prevention strategies for substance abuse. They found that preventative measures would save $3.69 for every $1 spent on prevention. The cost of substance abuse related crime in South Africa was about R20 billion in 2012 (fin24, 2012). Since only R213.3 million is allocated to substance abuse treatment, it appears that substance abuse related crime is more expensive than prevention intervention for South Africa. This fact in itself is a persuasive enough argument for the necessity of comprehensive treatment facilities in Cape Town and South Africa. Furthermore, with added substance abuse facilities in Cape Town and the rest of South Africa, the social, psychological and physical effects of substance abuse can be curbed (Jones et al., 2011, 2014; Ordean & Kahan, 2011). Admittedly, the solution for the negative consequences associated with substance abuse and substance abuse during pregnancy mentioned in this chapter extend far further than comprehensive care. However, comprehensive treatment facilities could be the starting point to addressing the TIK epidemic among pregnant coloured females in Cape Town.

A study of the available literature showed that most studies focused on the treatment barriers from the patient's perspective, while studies that focused on structural treatment barriers from the healthcare providers' perspective have received less attention. The current literature suggests that the problem of substance abuse during pregnancy is multifaceted and addressing treatment barriers on both platforms of maternal and substance abuse treatment is necessary for treatment to be effective (Jones et al., 2011, 2014). It is thus important to place focus on the barriers to treatment from the healthcare providers' perspective in order to gain

an understanding of the barriers that exist within the multifaceted problem of TIK abuse during pregnancy. The current literature on the structural barriers experienced by healthcare providers that treat individuals with different conditions was informative; however the structural barriers that may arise specifically regarding substance abuse amongst pregnant coloured women may differ (Coetzee et al., 2011; Kalichman, Kalichman, & Cherry, 2015; Myers, Louw, & Fakier, 2008). Therefore, there is a need to explore the subject of the structural barriers to the treatment of pregnant coloured women abusing TIK from the healthcare providers' perspective. The aim of the present study is thus to uncover the structural barriers that hinder healthcare providers' effective treatment of this group of women.

2.6 Theoretical Framework

According to Jensen (2008a) a theoretical framework in qualitative research is the lens through which the research process is viewed. Similarly, Anfara, & Mertz (2006) state that a theoretical framework spreads beyond the boundaries of one particular study and plays a vital role in any research process. Without the explicit decision to make use of a theoretical framework, most empirical studies are informed by an underlying epistemology from which the investigator functions (Tudge, Mokrova, Hatfield, & Karnik, 2009). However, as noted by Sales et al. (2006), a theoretical framework must be rooted in the planning and forming of interventions and not based solely within structuring and contextualising research.

Numerous theories were consulted before coming to a decision about a suitable theoretical framework for the present study. These included both the biopsychosocial model (Engel, 1980) and first and second order cybernetics (Bateson, 1972, 1949). The biopsychosocial model considers the existence of biological, psychological and social factors within a continuum of natural systems and includes the psychological and social factors when approaching facets from a medical perspective (Engel, 1980). The theory of cybernetics is a systems theory that is focused on the patterns and organisation of systems and those who exist and interact within in it (Bateson, 1972).

Although both theories have a strong systemic approach, the theoretical framework that was chosen to inform the findings of this study is Bronfenbrenner's Ecological Systems Theory (Bronfenbrenner, 1979). Bronfenbrenner (1979) described human existence and behaviour to be a product of, and a reaction to a hierarchy of systems. The interrelated

systems of behaviour that extend from the individual to the broader sociocultural context are embedded within one another (Bronfenbrenner, U. & Morris, 2005). It is within the interdependent micro-, meso-, exo- and macro-system that proximal processes of interaction occur (Bronfenbrenner, 1994). By applying Bronfenbrenner's (1979) Ecological Systems Theory, the structural barriers that healthcare providers experience regarding treatment of pregnant coloured women abusing TIK were analysed. With data collected through semi-structured interviews, each structural barrier that emerged was contextualised in one of Bronfenbrenner's four systems. This analysis depicts the various systems in which the structural barriers to treatment exist and how each barrier hinders healthcare providers' ability to provide treatment.

The micro-system is the system in which the individual takes part in direct proximal interaction with another individual (Bronfenbrenner, 1979). Bronfenbrenner, (1979) states that, each individual interacts from the platform of their own belief system and personality. There is thus a psychological element to the micro-system where interactions can affect belief systems and emotions (Bronfenbrenner, 1994). For example, healthcare providers can have more than one relationship within one particular micro-system. Healthcare providers interact with patients in their workplace micro-system and likewise with family members in their home life micro-system.

The meso-system thus includes interaction between 2 or more of the individuals' micro-systems (Bronfenbrenner, 1979). In the meso-system, if an individual has problems in one of their micro-systems, it could negatively impact other micro-systems within their lives (Bronfenbrenner, 1994) For example, if healthcare providers have negative interactions with their patients, this could have an adverse impact on their interaction with their children or spouse.

The exo-system involves a larger system that consists of the interaction between meso- and micro-systems (Bronfenbrenner, 1979, 1994). The exo-system influences both the meso- and micro-systems without any direct contact or interaction. For example, decisions made within the healthcare providers' facility by the managerial team about how many hours constitutes one shift could determine, and possibly negatively affect, the healthcare providers' experiences in the workplace.

Lastly, the macro-system involves the culture in which an individual exists; it is referred to as the sociocultural context (Bronfenbrenner, 1979). It is comprised of societal and cultural norms, beliefs, traditions and attitudes. Interestingly, the effects of the macro-system can be seen in the functionality of the micro-, meso- and exo- systems. For example, due to the structural barriers to the delivery of sufficient and effective treatment, negative beliefs about, and attitudes towards government funded treatment develop.

The structural barriers to providing treatment to pregnant coloured women who abuse TIK as experienced by healthcare providers were contextualised through the use of Bronfenbrenner's Ecological Systems Theory. The structural barriers that healthcare providers experience were thus examined on each ecological level.

2.7 Summary

This chapter provided a comprehensive review of the current international and local literature in relation to the structural barriers that healthcare providers experience when delivering healthcare to pregnant coloured women abusing TIK. A brief overview of South African history to contextualise the healthcare system during and post-Apartheid was provided. In order to convey the problem of TIK abuse during pregnancy, the prevalence, as well as the effects of TIK abuse, was discussed. Furthermore, this review provided a summary of the chief structural barriers experienced by healthcare providers within facilities in both South Africa and abroad. Lastly, to conclude the chapter, Bronfenbrenner's (1979) Ecological Systems Theory was described and noted as the theoretical framework that was used to contextualise and interpret the findings of this study. In chapter three, a detailed description of the methodological process followed for this study will be provided.

Chapter 3: Research Methodology

3.1 Introduction

The following chapter will provide a detailed outline of the methodology used for this study. To begin, the research rationale reiterates the motivation for the present study. This is followed by the aims and objectives of the research. Furthermore, the research design as well as the advantages and disadvantages of using this design are discussed. Thereafter, sampling procedures as well as participant characteristics and data collection procedures are addressed. These are followed by an explanation of the process utilised for data analysis and a discussion of the methods used to uphold trustworthiness throughout the data collection and analysing process. Lastly, the ethical considerations of this study will be delineated.

3.2 Research Rationale

Structural barriers are hindering healthcare providers' ability to provide effective treatment to pregnant coloured women abusing TIK. This is an important problem to address because of the far reaching social effects that TIK abuse during pregnancy has on the mother, her child, her community and the child's future generation. Failing to treat a pregnant woman abusing TIK could lead to fatal outcomes for the mother as well as her child (Jones et al., 2011; Oei et al., 2011). Additionally, it could lead to further social repercussions such as the perpetuation of TIK abuse and TIK abuse during pregnancy, domestic violence and involvement in gangsterism (Kwiatkowski et al., 2014; Watt et al., 2014). Although there is existing research regarding the barriers to treatment from the patients' perspective, structural barriers to providing treatment experienced from the healthcare providers' perspective, specifically regarding treatment of pregnant coloured women abusing TIK, have yet to be documented.

Of the structural barriers documented in research regarding general substance abuse treatment, healthcare providers are faced with an array of political, organisational and environmental factors that make treating pregnant coloured women abusing TIK problematic (Jones et al., 2011; Myers et al., 2008; Oei et al., 2011; Xu, Wang, Rapp, & Carlson, 2007). These include a shortage of government funding and resources, inadequate numbers of qualified personnel and poor service availability and quality (Jones et al., 2011; Myers et al., 2008; Rapp et al., 2006). The present study thus aims to elucidate those structural barriers that healthcare providers experience that hinder their treatment of pregnant coloured women

abusing TIK in Cape Town. The study posits that by underlining the structural barriers, the information acquired may assist in the design of strategies to make comprehensive obstetric and substance abuse treatment available and effective for pregnant coloured women abusing TIK.

3.3 Research Question

The present study aimed to address the following question:

- What are the structural barriers that healthcare providers experience that hinder their ability to provide comprehensive treatment to pregnant coloured women abusing TIK?

3.4 Aims and Objectives

This study aimed to investigate the structural barriers experienced by healthcare providers when providing comprehensive treatment for pregnant coloured TIK-abusing women. The primary focus is on:

- exploring structural barriers experienced by healthcare providers in their workplace
- translating how these structural barriers affect effective treatment of pregnant coloured women abusing TIK
- interpreting what is needed for comprehensive treatment of these women

3.5 Research Design

Qualitative research is largely defined as an approach that endeavours to understand phenomena in ‘real-world’ settings, where findings do not result from statistical procedures but rather from allowing the event under study to unfold naturally (Patton, 1990). Qualitative research designs are perceived to have relatively low credibility by critics in the field of research due to their subjective nature (Shenton, 2004). According to Jones (1995), however, qualitative approaches are appropriate when researching structural aspects of a phenomenon as they take into consideration factors such as place, context and time. Thus, in order to understand the structural barriers that healthcare providers experience in this study, an exploratory qualitative research design was chosen. In comparison with a quantitative research design, which employs the use of statistical analysis to investigate the causal

relationships between variables in order to obtain quantifiable data (Golafshani, 2003), a qualitative approach allows for the illumination and deeper understanding of the experiences reported by participants.

Although time consuming by nature, this form of research design allows for the gathering of vast amounts of in-depth information and descriptions of the healthcare providers' experiences of the barriers they experience. This ultimately allows for a comprehensive understanding of the chosen topic and for the achievement of the current project's aims and objectives as mentioned in section 3.4 (Golafshani, 2003; Patton, 1990).

3.6 Research Method

Semi-structured interviews have been chosen as the method of data collection in this study due to their usefulness in drawing out information on a specific topic (Bless, Higson-Smith, & Kagee, 2006). (Jensen, 2008a) describes semi-structured interviews as a method with explicit research goals that contribute to the yielding of findings that are comparative and representative. While unstructured interviews do not contain any formulated questions, and structured interviews follow only the set list of questions, semi-structured interviews provide a middle ground (Bless et al., 2006). This middle ground is situated between my guided questions and probing techniques used to expand the participants' responses in order to gather useful information (Jensen, 2008a; Opdenakker, 2006). Thus, within the interviews of the present study, probing techniques were used to compensate for possible shortcomings regarding the participants' recall and ability to describe their experiences (Jensen, 2008a). Furthermore, in order to avoid misinterpretation and inaccuracy in taking notes, interviews were recorded and later transcribed for analysis (Jensen, 2008a). Although a time-consuming and costly process, semi-structured interviews allow in-depth information to be gathered directly from the participants and revisited for closer analysis at a later stage. Thus they were the chosen method for data collection in this study.

3.7 Sampling

In order to identify and recruit participants for the present study, a purposeful sampling approach was used. Purposeful sampling is defined as the method of selecting research participants based upon specific criteria (Bless et al., 2006). This allows me to choose specific participants that provide the most in-depth data on the research topic (Patton, 1990). Purposeful sampling for this study, thus, required the participants to be from a specific

sample of healthcare providers from which the most knowledge and insight, about the topic, i.e. structural barriers to providing healthcare for pregnant coloured women abusing TIK, can be gained (Merriam, 1998). Firstly, the facilities in which to locate the participants were chosen based on their location within coloured communities in Cape Town. Part of the inclusion criteria for the participants was thus that they must be a healthcare provider within a government-funded facility situated in a coloured community in the Cape Town area. Secondly, a participant was required to be - or have been - involved in the treatment and recovery process of coloured females who are abusing - or have abused - TIK, as well as coloured females who are abusing or have abused TIK while pregnant. Healthcare providers within this study include nursing sisters, midwives, general practitioners, psychiatrists, psychologists, counsellors, social workers and occupational therapists.

In the words of Patton (1990, p.184), “there are no rules for sample size in qualitative inquiry”. Patton (1990), states that choosing a sample size depends on the purpose of the inquiry, what information will be useful and what will yield the greatest amount of credibility. Guest, Bunce, & Johnson (2006), suggest that for purposive sampling, sampling should cease at the point of data saturation or theoretical saturation. Although the wide use of this term has resulted in broad and vague definitions, Guest et al. (2006), define theoretical saturation as the point in data collection where no new information appears and in data analysis where no new codes arise. In order to achieve the study’s objectives, it was agreed between me and my supervisor that 10 to 12 participants would most likely be sufficient. I was able to arrange fifteen meetings for interviews in the two months that had been set aside for data collection. However, by the eleventh interview, it was noticed that certain themes were reappearing in the interviews. Furthermore, it was also noticed that no new information was forthcoming.

All fifteen standing appointments were, however, completed even though data saturation had been reached by interview eleven. Throughout the interviewing process, I had hoped to interview healthcare providers at the only female substance abuse facility in Cape Town. After accepting that I would not receive ethical clearance to conduct interviews at this facility before my data collection deadline, my clearance was granted, though this was late in the interview process. Interview sixteen and seventeen were thus vital as participants employed at this facility matched all of the inclusion criteria. It was only possible to arrange two interviews though as healthcare providers at the facility were busy with finalising

arrangements for the closing of the treatment centre at the end of June 2016. These last two interviews thus provided the sixteenth and seventeenth interview, totalling 20 participants across all 17 interviews. It is important to note that 2 of the 17 interviews had more than one interviewee at one time. Healthcare providers for interview 12 had extremely tight schedules; thus it was easier for the participants if the interviews were conducted in this manner. Similarly, interview two was initially conducted with one participant, but another participant joined the interview early enough to answer the questions sufficiently. See appendix F for participant profiles.

The ages of the 20 participants that were interviewed for this study, ranged from 25 to 64 (mean = 40) years. Two of the participants were male (10%) and 18 participants were female (90%). The participants consist of two white males (10%), 15 coloured females (75%), two white females (10%) and one African female (5%). Six participants were social workers (30%), seven were nurses (40%) and one was a midwife (5%). Two participants, one male and one female, were facility managers (10%) with their respective qualifications being nursing and psychiatry. Two participants were registered counsellors (10%), one played an administrative role (5%) and one was a psychologist (5%). The years of experience as a healthcare provider ranged from one to 42 (median = 8.25 and mean = 14.7) among the participants (see Table 3.1).

Due to the variability of professions between participants, this sample can be classified as heterogeneous. There was a substantial difference between the age of the youngest (25 years old) and that of the oldest participant (64 years old). Furthermore, there was a substantial difference between the least (2 years) and most (42 years) years of experience. However, because factors such as the age and race of the participants are outside the scope of the present study, the variation was not considered valuable or influential to the study.

Table 3.1

Demographic Description of Participants

Participant Code	Age	Race	Gender	Profession	Years of healthcare experience
M1	36	White	Male	Psychiatry	12
F2	31	Coloured	Female	Social Work	2
F2	30	Coloured	Female	Social Work	3
F4	64	White	Female	Nurse	34
M5	25	White	Male	Counsellor	3
F6	32	Coloured	Female	Social Work	7,5
F7	61	Coloured	Female	Nurse	30
F8	51	Coloured	Female	Nurse	30
F9	48	Coloured	Female	Nurse	12
F10	29	Coloured	Female	Midwife	7
F11	60	Coloured	Female	Nurse	42
F12	43	Coloured	Female	Social Work	12
F13	32	African	Female	Social Work	9
F14	36	Coloured	Female	Nurse	8
F15	33	Coloured	Female	Admin	16
F16	28	Coloured	Female	Counsellor	3,5
F17	38	Coloured	Female	Social Work	10
F18	38	Coloured	Female	Nurse	9
F19	56	Coloured	Female	Nurse	40
F20	28	Coloured	Female	Psychologist	4

Note: Participant code: F= Female; M= Male; 1 = Number of interview
Profession = the field in which healthcare providers are currently employed and rendering services

3.8 Data collection

Healthcare providers were located at various rehabilitation facilities and health care clinics within coloured communities in and around Cape Town. These include: Kensington

Clinic in Maitland, which is the only government-funded female rehabilitation facility in the Western Cape and offers substance abuse treatment to 40 women at a time, and SANCA treatment centres in Athlone and Tygerberg. SANCA is a non-governmental organisation established in 1956. Its chief concerns are the prevention and treatment of alcohol and drug dependence and the aftercare of drug-dependent patients. Also selected were Tygerberg Hospital in Bellville, which is the tertiary hospital affiliated with Stellenbosch University's medical campus, Matrix clinics in Albow Gardens in Brooklyn, Milnerton, Delft in Delft South, Ravensmead in Parow and Tafelsig in Mitchells Plain. The Matrix Model for drug and alcohol treatment is part of the ISAP (Integrated Substance Abuse Programmes) at the University of Los Angeles and was incorporated into primary health clinics in Cape Town in 2008. The Matrix Model is an intensive out-patient treatment program that provides integrative treatment and educates individuals who abuse substances about the factors surrounding addiction and relapse (Pascoe, 2010).

In accordance with purposive sampling, as seen in section 3.6, the abovementioned facilities were selected because they were situated within coloured communities and employed participants that met the inclusion criteria. The ethical clearance process of applying online to the Department of Health, Department of Social Development and the City of Cape Town websites was followed. Unfortunately, the outcome of the application to the Department of Health was not received in time and thus resulted in missed opportunities to interview healthcare providers at MOU's (Maternal Obstetric Units), CHC's (Community Health Centres), tertiary hospitals, and psychiatric facilities (such as Valkenberg) in and around Cape Town. Furthermore, the Department of Social Development informed that they could not offer ethical clearance for the Kensington Treatment Facility as the facility was partly privately sponsored. It was thus necessary to obtain permission from the Kensington facility managers in order to interview participants at the facility. This was a time consuming process as both facility managers were busy with arrangements for the closing of the facility at the end of June 2016. However, I was able to obtain clearance from the facility manager to conduct interviews there.

Permission for Albow Gardens, Delft, Ravensmead, Tafelsig Matrix Clinics and in Athlone and Tygerberg was obtained from the City of Cape Town. Permission for Tygerberg Hospital was received from the Western Cape government, Research Projects Department with the reference number given as being SU-HSD-001867. Further permission was needed

from the head of the research division at Tygerberg Hospital who stipulated that the interviews should be conducted outside working hours (during tea or lunch time) as interviewing during working hours would have a negative effect on the hospital's operations.

Data collection took place during the months of May and June of 2016. Once the necessary ethical clearance and permission was obtained, participants were invited to take part in this study via email or telephone. Emails were sent out to all potential participants and those who did not respond were contacted telephonically. It was through this method that once-off semi-structured interviews were arranged at a time and place that best suited these participants. Healthcare providers were thus met at their workplace and the interview was conducted in a quiet room within the facility.

Before the commencement of data collection, participants were informed of the aim of the study and their rights and responsibilities as research participants. They were asked to sign an informed consent agreement and they gave permission to record the interview prior to the signing of the informed consent form (See appendix D for informed consent). Once consent was received and the participant was fully aware of the necessary information regarding the study and their rights, a biographical questionnaire was provided. This was to record the participants age, gender, race, home language, qualification and number of years as a practising healthcare provider (See Appendix C for biographical questionnaire). Subsequently, participants were asked open-ended interview questions in order to obtain insights into their experiences of structural barriers that hinder their ability to comprehensively and effectively treat pregnant coloured women abusing TIK (See Appendix E for interview questions).

The interviews were opened by thanking the participants for their time, and reminding them that any information they provided would be confidential and anonymous. Final verbal consent was obtained to record the interviews, which lasted from 28 – 45 minutes, and included questions aimed at probing the participants' answers. Such questions were used to gain a complete in-depth understanding of the information provided by each participant. Each interview was ended by thanking the participant for their time and the valuable information that they had provided.

3.9 Data Analysis

Patton (1990), states that qualitative research is full of ambiguities and seems to work best for researchers with a high acceptance of ambiguity. Similarly Thorne (2000), wrote that in qualitative research, analysis is the most complicated and intricate phase of a project. The most frequently used qualitative analysis methods include ethnography, discourse analysis, grounded theory and thematic analysis, all of which have code development in common. Ethnographic studies, which make use of observing participants within a particular context, include the element of phenomenology (Thorne, 2000). However, the examination of participants within their workplace setting, namely healthcare and substance abuse facilities, in order to uncover cultural norms and rules, showed that an ethnographic approach was inappropriate for this project.

Discourse analysis considers language to be the key to analysis, stating that language is formed by ideological and societal influences (Thorne, 2000). The key focus is on how participants communicate instead of what the participant is communicating. As the present study's focus is on the actual experiences of participants and not about how they communicate, discourse analysis would not be fitting for this project. Grounded theory on the other hand is based on the premise that the iterative process of building theories about phenomena is the key to qualitative research (Thorne, 2000). Though all three methods make use of the development of codes that emerge from the data, thematic analysis was deemed the most appropriate for the present study. Thematic analysis is used to identify, analyse and report themes that arise from within data (Braun & Clarke, 2006).

3.9.1 Thematic Analysis

In order to highlight the chief barriers to treatment experienced by healthcare providers when treating pregnant coloured women abusing TIK, thematic analysis was used to analyse the data. Although the dearth of literature about thematic analysis accounts for its shortcomings regarding transparency and definition, this method has been shown to inform the identification of prominent themes within data as well as methods of structuring those themes (Dixon-Woods, Agarwal, Jones, Young, & Sutton, 2005; Fereday & Muir-Cochrane, 2006). More specifically, Braun & Clarke's (2006) article on using thematic analysis in psychology provides a useful guide for thematic analysis. These authors state that what differentiates thematic analysis from other methods that find patterns within data is that it is

not bound to any one specific theoretical framework and can thus be applied across various theoretical frameworks (Braun & Clarke, 2006). Due to thematic analysis not being theoretically bound, it can be used in an essentialist manner, optimising its use for reporting experiences, meanings and the reality of participants (Braun & Clarke, 2006).

Braun & Clarke (2006), state that thematic analysis is advantageous for novice researchers. It is a simple and flexible method that allows themes to be identified in a number of ways while maintaining the production of thick data descriptions (Braun & Clarke, 2006). There are, however, some disadvantages to the approach which warrant consideration, notably the fact that the thematic analysis can be applied from two viewpoints. Firstly, it can be data focused, whereby themes are identified within the data to create theories. Secondly, it can be theory driven, meaning themes are documented in order to substantiate or disprove existing theories (Dixon-Woods et al., 2005). Many researchers fail to highlight the exact procedures of their analysis and to specify which approach they use, causing a lack of transparency and clarity in analysis (Dixon-Woods et al., 2005). For this study however, the first method is employed.

Dixon-Woods et al. (2005), also state that thematic analysis appears to be a mere summary of themes that appear from data. The fact that it does not belong to a specific theoretical framework creates the advantage that this method can be vastly applied. However, if it not used within a particular framework to support my assertions, it is a mere summary of common themes across the recorded data. To avoid this summarising aspect, thematic analysis was conducted in conjunction with the theoretical framework of Bronfenbrenner's Ecological Systems Theory (Bronfenbrenner, 1979).

In order to ensure the production of an insightful and applicable analysis that answers the research questions in section 3.3, Braun & Clarke's (2006) six steps of thematic analysis were used in this study in a meticulous manner. Applying the six steps of thematic analysis allowed me to accurately elucidate the experiences of healthcare providers who treat pregnant coloured women abusers of TIK. It also allowed me to highlight themes and subthemes within the data collected and analyse them through the lens of Bronfenbrenner's Ecological Systems Theory (Bronfenbrenner, 1979).

3.9.2 Six steps of thematic analysis

For the analysis applied in the present study, Bronfenbrenner's (1979) Ecological Systems Theory was used in combination with Braun & Clarke's (2006) six steps to thematic analysis. Through the steps taken in completing thematic analysis, each potential theme and sub-theme's applicability was tested within the systems of Bronfenbrenner's (1979) Ecological Systems Theory. Each theme that emerged was compared to the definition of the respective system level in order to determine to which system it was most appropriately applicable.

According to Braun & Clarke (2006), the first step to thematic analysis is immersing oneself in and familiarising oneself with the data. I conducted and transcribed all 17 interviews, allowing patterns to be formed as the interview and transcribing process occurred. Transcriptions of the recorded interviews were entered directly into ATLAS ti, version 7.5.10 (www.ATLASti.com), the analysis tool used to conduct thematic analysis. ATLAS ti is a Computer Assisted Qualitative Data Analysis Software (CAQDAS) used to manage rich-text, audio and graphical data (Jensen, 2008a). ATLAS ti was chosen above other CAQDAS programs because I have had training with this program and thus has knowledge of how to use it. Use of ATLAS ti is beneficial for qualitative research because of its ability to apply rigor and consistency in a time-effective manner (Jensen, 2008b). Furthermore, it provides access to more complicated forms of analysis and proves useful for linking codes and forming networks of codes which assist in the formation of themes (Jensen, 2008b). Once the interviews had been transcribed into the ATLAS ti program, the transcriptions were read and re-read alongside the recordings to make sure that there were no mistakes made during the transcription process. During this first step of thematic analysis, some patterns had already been noted within the data and some ideas were written down pertaining to these emerging patterns.

Step two of Braun & Clarke's (2006) guide is generating codes. This process entails identifying unique and noteworthy pieces of data and collating them with their relevant codes in a systematic manner. Codes were formulated during the process of transcription when it was noticed that certain patterns relevant to the research question were forming within the data. Within the program of ATLAS ti, the transcription documents were saved within in one HU (hermeneutic unit). To begin the coding process, a list of codes was established that had been formulated during the reading of the transcriptions. The coding process included

highlighting words and phrases that were recorded as quotations. These quotations were allocated codes by using one of the three coding options namely: 'Select codes from list' where an appropriate code could be selected from a pre-established list that I had entered before starting the coding process. The second option is 'Code by name' where the code name was entered manually. The third option is 'code in vivo', where the selected word or phrase was used as the code if it was not on the pre-established list of codes.

Once codes had been formulated through highlighting words and phrases within the data, the ATLAS ti code manager was accessed to obtain a comprehensive list of all of the codes marked and the amount of times the code was used. This allowed me to follow the third step to thematic analysis, namely to sort through codes to merge those that are similar, and collate these codes into potential themes (Braun & Clarke, 2006). Using my personal interpretation of the list of codes, each code was placed into a code family within the ATLAS ti program, thus collating the codes and their extracts within a potential theme (Braun & Clarke, 2006). Potential themes were formulated based on the frequency that each code, attached to its respective quotation, appeared. A visual representation of the potential theme that contained its respective codes and quotations was created using the 'network' application within ATLAS ti. This was done in order to be better able to organise potential themes and sub-themes (Braun & Clarke, 2006). Aronson (1994) defines a theme as a unit that is derived from a pattern that is formulated by combining components of experiences that are not valuable when they stand individually. More simply put, themes are defined by Braun & Clarke (2006), as information that arises regularly within and across data sets. Themes can be chosen in a number of ways, one of which is to choose themes that inform and help answer the research question (Braun & Clarke, 2006). For the present study, themes were chosen based on their capacity to answer the research question (Braun & Clarke, 2006). Thus, potential themes were chosen that represent the structural barriers experienced by healthcare providers when treating pregnant coloured women who abuse TIK. Some examples of these themes include overburdened staff, problems with the referral system (specifically related to pregnant coloured females abusing TIK) and challenges regarding funding. These potential themes and their application to the respective system levels were discussed my supervisor who informed her that the themes needed to be refined.

Making use of step four in thematic analysis, that is, in refining the initial themes created by using the coding families generated in ATLAS ti, it became apparent that too

many themes had been created for the scope of discussion in the present study. Therefore, those themes that did not have enough data to substantiate them were deleted and those that were very similar were collapsed into one potential theme (Braun & Clarke, 2006). In addition, it was initially important to make sure that the data within each theme was coherent, and then there was a need to ensure that there was a clear distinction between each theme (Braun & Clarke, 2006). In accordance with Braun & Clarke's (2006) guide, both methods of refining themes were used. For the first method, each theme was revisited by re-reading both the codes as well as their associated quotations. At this level, some quotations that did not form part of a pattern were removed or merged with a different theme (Braun & Clarke, 2006). This ensured that all quotations that were coded formed a coherent pattern. Applying the second method, an entire data set from a broader level was looked at (Braun & Clarke, 2006). This approach to refining themes entailed looking at the data set as a whole to ascertain whether the selected themes represented it, and to ensure, in order to substantiate the selection of themes, that there was a clear distinction between these themes. This method also required a confirmation that no codes had been left out during the early stages of code development (Braun & Clarke, 2006). From this the content of each theme was determined, as well as the link between each theme, and note was taken of what the themes revealed about the data (Braun & Clarke, 2006). Upon completion of this step, in consultation with the supervisor, themes were discussed, amended and agreed upon.

Engaging in the fifth step of thematic analysis, I refined the themes even further, by delving more deeply into individual themes that had been identified (Braun & Clarke, 2006). It is within this step that I prepared each theme for the presentation of her analysis (Braun & Clarke, 2006). To identify the crux of the themes, I returned to each theme’s respective collated excerpts and organised them using a comprehensive account of the data with appropriate quotations. It was by following step five of thematic analysis that I was able to properly define each theme and to stipulate what each theme is not. Furthermore, it was through this step that the themes and sub-themes were finalised (Braun & Clarke, 2006). In consultation with the supervisor, I revised and refined the themes and sub-themes one more time before preparing them for presentation of the findings.

The sixth step of thematic analysis, entailed writing a detailed report that contained examples validating the central argument (Braun & Clarke, 2006). In order to merit the validity of the data analysis, direct quotations, extracted from the data that substantiated the

identified themes were used (Braun & Clarke, 2006). In order to avoid simply summarising the findings of the analysis, clear examples were used to engage in an analytical narrative about the themes and their place within Bronfenbrenner's (1979) Ecological Systems Theory. This is to make the overarching argument clear to the reader in a concise yet non-repetitive and interesting manner (Braun & Clarke, 2006). In Chapter 4 the findings will be discussed and the chief themes and sub-themes identified in answering the research question will be highlighted and explained.

3.10 Maintaining Trustworthiness

According to Patton (1990), within quantitative research, the credibility of the research depends on the construction of the research instrument. In qualitative research, however, I as the researcher, am the instrument (Patton, 1990). This means that in qualitative research, the credibility of the study depends on my ability to ensure it. Qualitative studies do not aim to establish reliability and validity, but rather trustworthiness (Patton, 1990; Shenton, 2004). Within any qualitative study, trustworthiness of research is imperative. Emphasising the need for rigor within the present study, the four criteria of trustworthiness established by Lincoln & Guba, (1985) namely, credibility, transferability, dependability and confirmability were applied

3.10.1 Credibility, is described by Lincoln & Guba (1985), as the most important aspect of establishing trustworthiness. Ensuring congruence between the participants' expressions and my impressions thereof, is a means to establish credibility in qualitative research (Jensen, 2008c). Credibility is thus equivalent to internal validity in quantitative research (Golafshani, 2003). In order to ensure the credibility of the present study, four methods were applied.

3.10.1.1 Member checks. Member checks carry the most importance in ensuring a qualitative study's credibility (Shenton, 2004). Through the use of member checks, healthcare providers were given the opportunity to verify that my understanding and interpretation of their reports were correct throughout the interviews. Member checks were used to confirm whether or not the findings accurately represented the participants' perspective (Lincoln & Guba, 1985). Furthermore, during each interview, opinions of previous participants were brought into the conversation when new participants were asked to reflect on previous participants' experiences. This is another form of the member checking that was applied to the

present study in order to ask participants for possible reasons as to why certain patterns were emerging in the data, as well as to understand these patterns better (Lincoln & Guba, 1985; Shenton, 2004).

***3.10.1.2. Debriefing sessions*.** Regular debriefing sessions**,** according to Lincoln & Guba (1985), can be used to increase credibility as they provide a 'sounding board' for me to air ideas and check interpretations of emerging patterns in the data. Debriefing sessions for the present study were conducted with my supervisor and those peers that had qualitative research knowledge (Shenton, 2004). Peer ideas regarding appropriate methods and findings were compared during collaborative sessions in order to eradicate bias and misinterpretation of the data (Lincoln & Guba, 1985).

***3.10.1.3 Peer Inspection*.** Criticism from peers, colleagues and academics provide renewed perspectives that challenge my assumptions (Lincoln & Guba, 1985; Shenton, 2004). In making use of the method of peer scrutiny throughout the research process, I consulted with my peers with expertise in the field of qualitative research in the disciplines of social anthropology, law and speech therapy. It was these additional interpretations throughout the collection and analysis phases of this project that drew attention to various flaws and biases within the research (Shenton, 2004).

***3.10.1.4 Ensuring honesty*.** To ensure honesty from healthcare providers during interviews, all participants were given the opportunity to refuse to participate in the research process thus ensuring that participation remained voluntary (Lincoln & Guba, 1985). This allowed for the filtering out of those participants not willing to offer information honestly and freely. Furthermore, my independent status, as well as the confidentiality and anonymity of participant information were emphasised (Shenton, 2004). This put healthcare providers at ease regarding their reports of experiences within their healthcare facilities. It was ensured that healthcare providers were aware that withdrawal from participation was possible at any time during the study, without explanation or consequence. This guaranteed that all participants willing to take part in the study were aware of the exposing nature of the information that they were providing, but that it would be kept confidential.

3.10.2 Transferability of data refers to its ability to be applied in different contexts, that are not within the confines of the phenomenon being studied (Jensen, 2008d). Just as credibility is associated with internal validity in quantitative research, so transferability in

qualitative research is the equivalent of external validity in quantitative research (Long & Johnson, 2000; Shenton, 2004). Transferability is thus the extent to which a study's findings can be generalised to another population (Shenton, 2004). For the present study, in order to make sure of the transferability of the research, a thick description method was employed.

3.10.2.1 Thick description Data. Data was recorded using thick descriptions to ensure sufficient context and perspective of the structural barriers being investigated. This will give the reader enough insight and background to determine whether the overall findings are accurate. Thick contextual descriptions will allow readers to draw their own conclusions and make use of the findings in other spheres of research.

3.10.3 Dependability refers to a study's ability to be replicated, so that the same findings result, even if historical effects and maturation occurs (Jensen, 2008e). In qualitative research, dependability is equivalent to the concept of reliability in quantitative research (Shenton, 2004). To contribute to the present study's replicability, an in-depth description of the research methodology that was used to conduct the study is provided (Lincoln & Guba, 1985; Shenton, 2004). This includes the research design, its implementation and the method of data collection and analysis. This detailed report of the methodology used in the present study will ensure the replication of this study in future research as well as allow the reader to assess whether the methods used were appropriate (Shenton, 2004).

3.10.4 Confirmability concerns my objectivity with the role of the researcher and is achieved when the credibility, transferability and dependability of a study have been established (Krefting, 1991). The findings of a study should thus be based solely on the purpose of the research and not be skewed in any way due to my own perceptions or beliefs (Morse, Olson, & Spiers, 2002; Shenton, 2004). What makes this practice difficult is that qualitative research cannot be free from subjectivity (Krefting, 1991; Lincoln & Guba, 1985). In order to keep the present study confirmable, I ensured that I remained aware of my own preconceived ideas, beliefs and predispositions throughout the research process. Furthermore, sharing interpretations of the data with my supervisor and peers helped me to recognise where my ideas and beliefs may have been affecting my interpretation. In order to make sure that the findings of the present study were the outcome of the participants' experiences and not my own inclinations, the method of triangulation was used (Lincoln & Guba, 1985).

3.10.4.1 Triangulation refers to the utilization of multiple methods of data collection, sources of data, investigators, analysers and theories (Long & Johnson, 2000). Multiple sources and methods are used in order to forego the effects on the research project of the shortcomings and disadvantages of one particular method or source (Long & Johnson, 2000; Shenton, 2004). This, in turn, reduces the presence of my own bias. According to Krefting (1991), triangulating data sources expands the range of data that provides insight into a specific concept. For the present study, although the particular group of focus is healthcare providers that are or have been involved in the treatment of pregnant coloured women who abuse TIK, a sample of 20 healthcare providers within various fields of healthcare were recruited. Social workers, counsellors, psychologists, facility managers, nurses, and midwives were interviewed in order to understand, from all facets of treatment, the structural barriers encountered by pregnant coloured women who abuse TIK. Participants were also diversified between the variables of race, gender, age and years of healthcare experience. Furthermore, triangulation of researchers during the analysis phase of the present study was used when my supervisor and I had discussed possible themes. Once incongruities had been discussed and settled upon, the final themes were reported on.

***3.10.4.2 Self Reflection*.** Self-reflection is regarded by Long and Johnson (2000) as one of the most important aspects of the qualitative research process. They state that it compels researchers to reflect on their own opinions and beliefs in the same way that they would approach their participants' opinions and beliefs (Long & Johnson, 2000). In my experience of the present study's research process, I felt that I was able to engage in self-reflection to the extent that it minimised bias. The fact that I am a 26-year-old master's degree student who is a novice in the field of qualitative research was considered. Furthermore, before conducting the present study, I had little knowledge of TIK, its effects during pregnancy, the South African health system and structural barriers that hinder effective treatment. To prepare for interviews, I performed extensive research and reading around all of these topics.

To conduct the interviews for the study, I was required to drive to places in Cape Town that I had never been before. Being a young white female, I felt anxious about travelling into townships and unsafe neighbourhoods. After a few times however, I learnt how to calm my nerves and focus on the project at hand. Once I had arrived at the facilities, conditions were chaotic, with patients queuing out of the door and babies crying. I felt unsure

where to find the participant with which I had scheduled the interview, but decided that I would ask at reception. The receptionists at each facility were very helpful and I was thus easily able to find the participant for that day.

Over and above the distances travelled and unsafe areas that had to be visited, I was concerned that, being a student conducting research, I would not be well received by the participants as their busy schedules made it difficult for them to leave their posts. I felt pressured for time, especially when participants' colleagues interrupted interviews to ask questions regarding patients. However, participants were apologetic for how busy the facilities were and were always polite about the interruptions. It was clear that it was important to them to talk about their experiences.

I also had to bear in mind that, because participants were on a tight schedule, my questions may not be answered as thoroughly as if participants had more time available and were more relaxed. However, once the participants began to speak about the barriers they experience, it seemed as though they used the interview space to express their unhappiness and dissatisfaction with their workplace.

Despite these experiences of interviewing participants for the first time, travelling through unsafe areas and interviewing participants who are under heavy time pressures, interviews were not negatively affected and the participants seemed to appreciate a platform to air their frustrations and workplace needs. Furthermore, the growth that I experienced throughout this process was invaluable. The challenges that I faced while travelling to meet participants strengthened my confidence and independence. Furthermore, the interviewing process expanded on my interactive skills and knowledge of the public healthcare sector. Moreover, the exposure to the life lived by those less fortunate then me, gave me a sense of appreciation for my circumstances. In consultation with my supervisor and throughout this process of self-reflection, I tried to minimise the impact of researcher bias in this study.

3.11 Ethical considerations

The research proposal for the present study was submitted to the Department of Psychology at Stellenbosch University and the Research Ethics committee (REC) at Stellenbosch University for review and ethical approval before the study commenced. Once

departmental and REC approval was obtained with reference number SU-HSD-001867, ethical approval was sought from the City of Cape Town, the Department of Health (DoH), The Department of Social Development (DoSD) and Tygerberg Hospital's Health Research Ethics Committee (HREC). Only once HREC approval was obtained with reference number SU-HSD-001867 and once granted by the City of Cape Town with ID Number 10564 did I begin to arrange interviews with healthcare providers at the respective facilities.

In accordance with ethical conduct, participants who had agreed to partake in the study were informed that the voluntary nature of their participation allowed them to withdraw from the study at any time with no explanation or repercussions. Once participants had provided signed, informed consent forms, they were briefed as to the particulars of the study, what was required of them and were assured of the confidentiality of the information they provided in the interviews.

Participant codes were used in the reporting of the data and findings so as to protect the identity of the participants. All interviews remained anonymous and identifiable details were excluded from the findings of the study. My supervisor and I were the only people with access to the recorded and transcribed data. While the study was underway, all data was locked in a secure cabinet and stored in a password-protected file on her computer. I am the only person who has the password for this file. The data will be kept in a protected location for five years following the completion of the study and thereafter will be destroyed appropriately.

The present study is classified as low risk. Even though research was conducted on a somewhat controversial topic, the nature of the participants and the information they were asked to provide allowed for minimal discomfort. The participants were adults (healthcare providers) and not considered to be a vulnerable research population. The research was composed of non-sensitive material given as opinions rather than personal information and this was collected anonymously through semi-structured interviews.

3.12 Summary

This chapter provided an in-depth description of the research methodology utilised for the completion of the present study. It contains a research rationale emphasising the necessity of obtaining information that was vital for addressing the structural barriers experienced by healthcare providers when treating pregnant coloured TIK abusing women in Cape Town,

South Africa. Thereafter, a summary followed of the aims and objectives of the study with specific focus on the structural barriers faced by healthcare providers. Subsequently, a report of the research design and method was provided, stating that an exploratory qualitative design was best suited for the study in order to gain the most appropriate data. Furthermore, it was mentioned that semi-structured interviews were used to elicit the experiences of the participants and that the processes of thematic analysis were used to analyse the transcriptions made from the interviews conducted. The steps taken in order to ensure the trustworthiness of the study were discussed and thereafter the ethical considerations of the study were described. The chapter to follow consists of the key findings of this study.

Chapter 4: Results

In this chapter, the findings of the present study will be systematically presented. Six themes with numerous sub-themes emerged from the data analysis of the semi-structured interviews conducted with the 20 participants constituting this study. Even though the participants varied in age, profession and years of experience in their respective fields, many similarities emerged regarding their experiences of the structural barriers to treating pregnant coloured women who abuse TIK. In table 4.1 below, is a summary of the themes and sub-themes as well as their categorisation according to their application within Bronfenbrenner's (1979) Ecological Systems Theory, namely the micro-, meso-, exo- and macro-systems. Themes and sub-themes are reported, not by level of importance, but rather from the most specific level (micro-system) to the broadest level (macro-system) of Bronfenbrenner's (1979) Ecological Systems Theory.

Table 4.1

Structural Treatment Barriers Experienced by Healthcare Providers

Level of EST	**Theme**	**Sub-theme**
Micro-system	4.1.1 Overburdened and under-resourced	4.1.1.1Burnout 4.1.1.2 Motivation and despondence 4.1.1.3Treatment style and efficacy (waiting time)
Meso-system	4.2.1 Referral	4.2.1.1 Referral within facility (across departments) 4.2.1.2 Fragmentation of services (across facilities) 4.2.1.3 Delay in services (protocol)
	4.2.3 Home life	
Exo-system	4.3.1 Healthcare providers cannot control outside influences	4.3.1.1 Drug-abusing environment 4.3.1.2 Women accessing treatment 4.3.1.3 Stigma around pregnancy and substance abuse 4.3.1.4 Transport affordability 4.3.1.5 Need too great for capacity
Macro-system	4.4.1Communication	
	4.5.1 Funding	4.4.2.1 Staff and resources 4.4.2.2 Infrastructure and space 4.4.2.3 Procurement

4.1. The Micro-system

It is within this system that interpersonal, bi-directional interactions occur and where people interact face-to-face (Bronfenbrenner, 1994). Each individual approaches these interactions with his/her own personality, beliefs and temperament and these influence the psychological functioning of other individuals (Paquette & Ryan, 2001). Individuals can have various micro-systems, including their workplace, home, school etc. Relevant to the present study is the workplace of healthcare providers. The theme of overburdened and under-resourced healthcare providers was placed within the micro-system due to its psychological nature. Sub-themes exist as a result of the bi-directional interaction between healthcare providers, their colleagues and their patients within overburdened and under-resourced circumstances. The sub-themes are as follows: burnout and despondence, lack of motivation, and treatment style and efficacy.

4.1.1 Overburdened and under-resourced

4.1.1.1 Burnout. Seventeen of the twenty healthcare providers reported that the daily demand for the treatment of patients is physically and psychologically draining. Nineteen healthcare providers, constituting 95% of the participants, noted that they cannot keep up with the demand for treatment.

There are some of us that are very unhappy because it feels like it's never ending you know? The demand is just getting greater. (F14)

You see you were sitting here. It's in and out, in and out. So you don't have the time. You don't have enough time to sit with them and really tell them the dangers (F9)

One of the participants, with over 40 years of experience reported treating more than 100 patients over her monthly target.

> Yeah, I have 250 patients per month right that we're supposed to see. I see over, 350, 380. So this is 391 we saw last month November. So this 400 I saw here, October. There's 387 if the month is short you know, there's public holidays. (F7)

As well as the high case load and demand for treatment, all 20 participants reported that the nature of the treatment they provide is psychologically and physically draining. Of the 20 participants, 10 participants working within the substance abuse field reported that the majority of treatment time is spent motivating patients to remain within the treatment program.

> You tell them [the patients] but sometimes they just don't listen. Sometimes there's just not enough time so then you tell them to condomise, don't have sex with that person or that client if he also came for treatment in the program. We tell them all those things, but then it's almost just a cycle that's repeating itself. (F14)

"Some of them will just come because they were referred, then we struggle with the lack of motivation and then they just stay away and report afterwards" (F6)

"We have to keep motivating them and they unpack that emotion. They actually feed off us, so we need to be motivated and we need to be positive all the time" (F2)

One participant, a social worker with 12 years of experience working with substance abusers went as far as to question whether her treatment efforts were a futile endeavour.

> You can become despondent because treatment for clients on substances, it's a voluntary process. So that is where the problem lies in terms of if that's person's not willing to come for treatment either. Or they are not willing to take your recommendation for referral then there is nothing that you are able to do about it and that makes you consider whether your impact is big enough. (F12)

Similarly, six of the seven nurses considered that educating patients about the dangers of substance abuse during pregnancy is their duty. Contrarily, however they reported that in some cases patients are aware of the dangers but continue their substance abuse during pregnancy anyway.

"Sometimes they don't, other times they do. Now the other day one of them said 'yoo! Sister but I drank with all my other babies, with all my children and they were big babies!' almost like they're proud man" (F14)

> All that we can do is to educate them on the risk of using while pregnant. That is all that we can do. At the end of the day it depends on the clients' motivation and willingness to stop. All that we can do, like I said is to just educate them because we can't give them medication or anything like that. (F6)

4.1.1.2 Motivation and despondence. Sixty-five per cent of healthcare providers reported feeling physically drained and emotionally depleted. It appears that the presence of burnout amongst healthcare providers resulting from the demands and the nature of treatment has a direct impact on their motivation on a physical, psychological and professional level. One counsellor described how she had lost motivation to dress professionally for work.

> You know we were chatting this morning; we both come from very professional settings you know, the way we dressed. My first week here I was so professional and now you are wearing uggs. So I swear, how we dress, only after a month has changed so much. (F3)

Another participant stated that she felt demotivated because her daily experience in the workplace is not that which she anticipated and for which she studied. A qualified mental health nurse, who loved her profession treating mentally ill patients, recounted that with the rise in the prevalence of TIK abuse, the nature of her treatment has shifted from diagnosing and treating legitimate psychosis to that of providing substance abuse treatment.

> Many of them aren't schizophrenic but they act like they are. Like a bipolar high or they are weird with the hallucinations, so they get the diagnosis of schizophrenia. The only way you can treat it is for them to stop so that you can see - do they still have the signs and symptoms and then you know you are treating a psychosis but it never stops…It's [psychiatric medication] not strong enough for the amount of TIK and things you use to suppress the psychosis. Some of them just don't get the crave anymore. So what's happening is we are now making out of a drug addict, we're making a psychiatric patient. We give him the psychotic, expensive medication, but he is still using drugs. It wasn't my liking at all. I never liked working with alcoholics and stuff so now I'm stuck with this now, part and parcel of my job… because it [TIK abuse] became a psychiatric problem. (F7)

Similarly, a nurse provided feedback based on her experience with fellow social workers. She states that they no longer feel that they are social workers dealing with social issues such as child abuse or domestic violence. Substance abuse is what she perceived that the majority of social workers deal with every day.

> They're not - they say they feel like they are not social workers anymore you know? Because substance abuse is so huge. Them having studied to look at the social environment; I mean they are very demotivated. There are two of them who are leaving now at the end of this month. It just gets too much. (F11)

4.1.1.3 Treatment style and efficacy. The feeling that their treatment is futile seems to have filtered into healthcare providers' treatment styles towards their patients. It appears to be an 'at least' treatment style where even the slightest improvement or prevention effort is considered better than no treatment at all. Fourteen participants noted that their treatment is affected by their despondence and lack of motivation. One nurse reported that she makes herself feel better by focusing on any slight change in behaviour in her patients. She derives comfort from the fact that throughout their treatment she was able to help in a small way.

> I try to hook them up and the patient sees that. I'll have the patient sit here while I phone the other facility and patient will say that also helps. They see the sister is really trying, you know? Sometimes they will come back and they will say thank you, and 'I'm smoking less now' you know? That sort of thing makes you think okay at least she's not using that much anymore; she's now cut down on her using. So at least I've done something. (F11)

Similarly, a social worker explained that when she sees a pregnant patient, if she can at least get her to stop abusing TIK during her pregnancy, then the baby will be in less danger.

> Yes, because you're just actually helping them along. I suppose you need to look at your treatment. It is just to meet the needs of a pregnant woman so that she is healthy to a certain extent, during that period of time. That is just your focus. You can't think for the person afterwards. That's often what we want to do and it kind of holds us back. It's neither here nor there. (F12)

Poor patient retention was reported by 16 participants as a source of a heightened level of frustration amongst healthcare providers, adding a dismissive element to their treatment style. A social worker with 10 years of experience in the field reports that she has realised that she has no control over what the patients decide to do regarding their treatment.

"It's their prerogative, we can provide the information but how they are going to be treated, how they are going to access it … it's on them" (F17)

Similarly, one of the nurses described her experience of some of her colleagues' treatment style:

> Kindness and consideration or just to become more human, it's very medical … cold. The term that they always use is 'cut yourself off … don't get involved'. That is something that for me personally, that gets me a lot. You are just a drug addict not a patient. (F19)

The treatment efficacy of healthcare providers became a point of focus during the interviewing process when 19 healthcare providers noted that waiting time affected their treatment efficacy. Although waiting time affects both maternal and substance abuse healthcare providers, the below mentioned participant quotations from substance abuse healthcare providers and maternal healthcare providers are separated. This is because long waiting periods for the different treatment services are caused by slightly different factors. For maternal healthcare providers, the treatment slots available are affected by time constraints. All 9 maternal healthcare providers noted that they have considerable time pressures and need to work quickly to be able to attend to all patients in need of treatment. To avoid deferring patients, all 9 of the maternal healthcare providers reported having to rush through appointments to get to the next patient.

> Yes. It's like, how do they say, like you're working in production? You don't produce quality, it's about quantity. It's quantity. You have to push, push, push, and you won't be able to spend that quality time and it's not the best, you slip … it just slips through. On Friday it happened like that. We were short-staffed and then we had to defer some clients because there were just not enough hands to help them. When we're done,

> those working in the other portfolios we all go and help but still, the demand is just too great. (F14)

> *"Like for instance now I'm in front, then I must go to the back to see a sick child, then there is no one in front then I must move, because we are short on staff. That makes you frustrated"* (F9)

> We have to be at least four sisters on call if you look at the amount of patients in the ward. Today we are two sisters attending to 34 patients. If your colleague cannot come in because of personal reasons then you alone are responsible for 34 patients. (F10)

One of the nurses stated that she does not have the time to treat all patients as quickly and as well as she would like, and also noted that she loses many patients because of this. Because of high volumes, patients are forced to wait for long periods to access treatment. She notices how alongside the frustration of the staff, patients also become frustrated and leave the facility.

> Then the patient also becomes frustrated because the patient is sitting here waiting and waiting and eventually she stands up and you lost someone. Which might have been something important because that patient is leaving and going someplace else or that patient just decides 'okay, I'm going to jol'. So you might lose say, a pregnant mommy there or someone who is looking for help who is on TIK. Then you lose that patient because you don't have time or you are too busy. (F9)

On the other hand, substance abuse treatment sectors make use of a walk-in policy, where patients can sit and wait to be seen without an appointment. Alongside the patients with a booked time-slot, walk-in patients are sometimes not attended to on busy days, and thus rethink their effort for substance abuse treatment. Eight out of ten substance abuse healthcare providers stated that because there are so few of them available to provide treatment, patients have to wait long periods of time before being attended to.

> Their average waiting time would be three hours depending for what service they come in for and it's subject also to staff availability. For example, with those off sick

> and on training or if we have a crisis but then we have a deferral policy that we use. (F18)

> You know, it's impossible to always be there. So, what happens is …my tooth had to be extracted on Wednesday. [Participant 2] is here but it really drains her out. When I get back I feel that she is drained out and vice versa. When talking about being short-staffed, it really affects our performance because we have people waiting. So in between your structured appointments, you have the people that walk in and the clients of your colleague who is not here. (F3)

"Everyone who abuses drugs struggles with waiting times and will have a hard time sitting here for a few hours waiting for an appointment. So possibly we need to try and find a system of fast tracking" (M1)

Although not noted by the majority of participants, one healthcare provider mentioned the ulterior motives of his patients as a barrier when treating them. He suggested that a manipulative characteristic within his patients makes it difficult for him to trust them and fully invest in treatment. This counselling psychologist reported feeling as if he never truly knows if he can believe his patients, as individuals abusing substances can be manipulative by nature.

> For me it's quite hard to deal with them because you don't know how truthful they are. The manipulative nature of the addict that is using is quite confusing for me at times. So actually gauging their sincerity; it's quite difficult. (M5)

> I think most of them won't even come back. It's only when there are legal procedures against them or social sanctions against them that they will return and be motivated for treatment. So sometimes I get the picture that they only come here to get their slate clean again and then after a period they will go back to their use. (M5)

4.2 Meso-system

The meso-system comprises the interaction between the micro-systems within which the healthcare provider exists. It thus includes interrelations in the two or more settings in

which the healthcare provider actively participates (Onwuegbuzi, Collins, & Frels, 2013). Naturally, the healthcare providers' meso-system includes all facets of their lives which are too wide for the scope of this study. Therefore, the two most prominent micro-systems affecting and affected by their workplace micro-system is the referral system (across departments and across facilities) and their home life.

4.2.1 Referral

4.2.1.1. Referral within facilities. Participants within primary healthcare clinics are able to refer pregnant coloured women abusing TIK to the substance abuse section of the clinic and vice versa. Fifteen of the twenty participants noted a smooth referral process within their facilities; however, there are structural barriers to accessing care once patients have been referred.

> Yes, there are still difficulties I mean obviously because the capacity of the staff, there are not that many staff. Sometimes the staff who are doing antenatal care are not there, and there's no one kind of doing it, BANC. So it's kind of those cases, and I think even with us it affects the women in that, for example if they've got a BANC appointment and the nurse that was supposed to be doing that is not there then it means that they have to wait longer. (F13)

One participant reported that it was a struggle in the beginning when substance abuse treatment was initially introduced into the clinic. Nurses were not happy about the 'extra clients' they had to book and treat.

> The reason why the [substance abuse] sites are part of the healthcare facilities is to access services. Yes, there were some hiccups when it comes to accessing services and care, but I mean it boiled down to our relationships with our colleagues. At this stage we don't have issues to refer our clients within the clinic, so should there be a request for a pregnancy test we will make an appointment. It might not be today, but there will be an appointment. (F17)

Interestingly, although both substance abuse treatment and maternal care are offered within primary healthcare clinics, a facility manager, who has been involved in the substance abuse section for more than eight years, was able to highlight that there is a gap in treatment for pregnant coloured women abusing TIK.

> They provide anti-natal services at the clinic here as well. The thing is that when the mother is also identified as a user, they are immediately categorised as high risk and they are moved out of this clinic and have to go to Mowbray maternity. That actually defeats the purpose because we could be a nice catchment area to work with these women. Ideally we would coordinate it that they would come for their maternity appointment and then we would schedule our appointment at the same time. They come to the clinic for two different services and then we can do it on the same day. That is something we can co-ordinate here easily. It becomes very difficult once she is referred and does not have access here for all her services. (M1)

4.2.1.2 Fragmentation of services. All 20 healthcare providers reported that substance-abusing pregnant women are classified as high risk patients that can only be treated at larger, better equipped facilities such as MOU's (Maternal Obstetric Unit) and hospitals. Six of the nine nurses reported that they are only trained and equipped for BANC (Basic Antenatal Care) and can therefore not treat pregnant substance abusing women and have to refer them onwards. It seems that on the basis of this referral, the fragmenting of maternal and substance abuse treatment occurs.

> If I can add, if I remember correctly before, this happened many years ago in Mitchells Plain, it was one of our clients and … if we found that it's one of our clients and we need to make an appointment for BANC, they would say sorry she is high-risk and needs to go to the MOU. (F16)

> Uhm, just we will have to refer because they are classified as a high risk so we have to refer. Then Karl Bremmer or Tygerberg they will start treatment immediately, we don't treat them, we don't give any drugs, we just refer, we make an appointment and we just see them either at Karl Bremmer or Tygerberg. I will still do the basic antenatal care and then refer them, but we don't start them on anything but we do give like, out education we will give to them and we will uhm, counsel them a little. (F9)

Similarly, a facility manager reports that, for pregnant coloured women abusing TIK, this defeats the objective of providing substance abuse treatment and maternal care in one facility.

> The moment they are transferred somewhere else, we do not have that luxury anymore and if someone drops out it can be very difficult to follow up. The point,

> when the city started this in 2008, was that we want to base it [substance abuse treatment] in health care facilities. Everyone can now get all the treatment under one roof. That is why the whole idea that high risk women have to get treatment somewhere else, kind of messes that up for us. (M1)

Within the facilities that do treat high-risk pregnant women abusing TIK, there is no provision for substance abuse treatment. One midwife reported that they liaise with a social worker who they refer to for pregnant women abusing TIK; however, the social worker focuses on the child and determining whether the mother is fit to care for the child rather than on treatment for the mother's substance abuse disorder.

> With admissions the patient will be admitted, but any patient that is abusing substances is referred. She is not discharged until she has seen a social worker because look, we have to care for the mother, but we must also be aware of where the baby is going when it is born. She is abusing drugs and everyone knows the outcome of drug abuse, not it all cases but we know in 90% of the cases. (F10)

> Many times we don't even see the patient, because they wait till the very last minute of their pregnancy then they go straight to the labour ward. So we don't see the totality of the women that abuse substances during their pregnancy. (F10)

Seventeen of the 20 participants interviewed placed emphasis on the fact that when they refer a patient, she does not return. They reported that this impinges on their ability to provide effective treatment for their patients.

> Yes, they don't really bother to come back. They have a social worker there, at Mowbray [Hospital] but she is more about protecting the child. Sometimes they do come back and we liaise with that social worker but it doesn't happen often. We understand because it's a high risk pregnancy so for the sake of the child, you know that confinement period. I think it is better, but then the mother still needs the support afterwards. So we need to find a way to kind of integrate the services. (F2)

One participant in particular, noted that she understands that the referral process makes it difficult for pregnant coloured women abusing TIK to access treatment at various places due to transport, money and time.

> Well, the sooner the better, but now there is the problem of referral. They need referral and sometimes there isn't money for them to travel. We need to refer. Sometimes they do go and sometimes they don't even go or they come back and say 'sister can you give me another day because I couldn't make it. I used my money for drugs'. The travelling in between, from here to that facility is a problem. From here to Tygerberg [Hospital] is okay, it's walking distance. To Karl Bremmer they will need to take a taxi and they will say they are in poverty. Patients don't have money for a taxi so they come back and say they couldn't go. Now you must make another appointment. So, in the meantime that patient is losing that time that they could have started on treatment already. So if treatment could be started here it would be much better. If the patient could be seen here at the facility when the patient is pregnant and is using drugs, we should be able to see the patient right here at the facility. (F9)

4.2.1.3 Delay in services due to protocol. Nine healthcare providers reported that the fragmentation of services and referral to different facilities creates a delay in treatment for their patients and serves as a barrier to their treatment. A lengthy process of accumulating the necessary documents to get a patient on the waiting list for an in-patient facility was noted as a barrier. By the time the administration and protocol is complete, there is a 6 month waiting list. Healthcare providers report that by this point their patient has lost interest in receiving treatment.

> First of all, the patient must be present when they apply for the rehab. They must go to social services voluntarily. When patients don't want to go, the parent can't put them in the rehab. If the patient does go, there is an application form to fill in and they must go make an appointment at the clinic for a physical examination to be done. Then, there's urine and semen test to check for infectious diseases and all that. That's the application form for the rehab – the general one. Then, they must go back to social services to apply. So that is where I have a problem because, now the patient doesn't want to come back for the doctor and then go back to the social worker. By the time the patient is in the middle of this process, we either lose them along the line or by the time they get the forms done, then they don't want to go anymore. (F7)

> Also, there's a big delay of services because first she has to come to SANCA for her substance care then she needs to go 10km … well she needs to walk sometimes for the pregnancy care and then for the general check-up with another doctor. Yes, so

> there is a big delay in services I think, because with any public service it is overburdened and under resourced. It is a big barrier. Government health is in need of services; general medical service. (M5)

"It varies. Sometimes it's for as long as 6 months. I've heard some of the patients say that. So I think that in itself is a challenge, the fact that there are not many facilities out there" (F20)

4.2.2 Home Life

The micro-system of the healthcare providers' home life and the experiences therein are directly and indirectly affected by the micro-system that is their work life. Seven healthcare providers reported that their demanding environment at work affects their mood and thus their experience at home. One social worker reported 'taking her work stresses home' (F3).

> You can become so absorbed in work mode that you forget the focus to home life and you start to take it home mentally. When you go home you are really drained and burn out is a big issue as well because you are taking on much more than you can handle. (F2)

Similarly, a counsellor reported being so tired that she is in bed by eight o'clock in the evening, cancelling quality time that she would have spent with her family members.

"I mean, when we have hectic days I am showered and in bed by eight o'clock. I can't I just can't…" (F3)

The same participant in particular, worked right up until one day before she gave birth. She was due two weeks later, but she had developed preeclampsia early in her pregnancy. This counsellor was admitted to hospital with potential kidney failure two weeks before she had to give birth, and thus had an emergency caesarean. She reported that she felt that she could not leave her patients as well as leave her colleagues to handle all of the patients alone.

> I was actually so sick, but felt that I couldn't take off to go to the doctor. What actually happened was, it became quite serious and my kidneys actually started failing

> because my blood pressure was that high. So then I immediately had to go do an emergency caesarean. Before that, when coming to work I was battling with different types of illnesses because you know when you're pregnant your immune system is down. When that happened it had an effect on me. I had to give birth early. Thank God that my child is fully developed. It could have been so different as well. Even now, we are constantly exposed to germs I mean we get sick more often than the average person. When we are off, it has a direct impact on service delivery and we deal with high-risk clients in the sense that, if they feel triggered and they maybe don't have the skills to deal with it, they need to come in and speak to somebody. So there has to be someone available and that's where it gets tricky. (F3)

4.3. Exo-system

The exo-system, which involves a large structure that consists of the interaction between meso- and micro-systems, influences both the meso- and micro-systems without any direct contact or interaction with the healthcare provider (Bronfenbrenner, 1979, 1994). In this case, there are a number of outside influences serving as barriers to treatment that healthcare providers cannot control.

4.3.1 Healthcare providers cannot control outside influences:

4.3.1.1 Drug-abusing environment. When questioned about the structural barriers that they experience on a daily basis, 18 out of 20 healthcare providers' mentioned the fact that they cannot control the outside influences that may affect the patients' motivation and ability to remain in treatment. It appears, throughout their reports that the patients' drug-abusing environment serves as a barrier to their treatment.

> We're talking about clients who are using with their parents or with their other siblings, that's most of their experience. So, that challenge, now they are in sobriety and they are leaving a home where people that are actively using and now they need to walk past somebody that's dealing and friends that have been using to get here, so the walk, even for them to get here, is quite a challenge. (F3)

> The fact that patients make progress while in treatment and then go back to dysfunctional families and the fact that the families resist coming in for family sessions is challenging. Sometimes the lack of openness and willingness from the

> families and the lack of support make treatment difficult. Also there is the issue of lack of finances for families to attend treatment sessions. So maybe there is a family that is willing to support, but there is a lack of finances. The fact that the patient goes back to a partner that is abusing substances and the patient might not have access to aftercare treatment owing to resources is quite challenging. (F20)

4.3.1.2 Women accessing treatment. A further challenge regarding external influences out of their control was indicated by 14 out of 20 participants who stated that they do not see pregnant coloured women abusing TIK. Out of the 10 substance abuse healthcare providers interviewed, all 10 reported that the majority of the patients they treat are male.

> We'll see some but not that many. Generally, you know that women accessing substance abuse treatment, the numbers are always low in comparison with men. So in the past we've been struggling to allow or get women. Not only get them but retain them. (F13)

> From our side I would say we don't see an overwhelming number of pregnant women; we see too little. There are a number of challenges that prevents them from coming to us. She is usually in a relationship with someone who is using. Just for her to get here, or the fact that she is staying in an environment where other people are using. Most of the people who come here are unemployed and so the only way for them to get here is by walking, not many can afford public transport to get here. (M1)

Based on the reports made by participants, the rate of women accessing treatment is also due to the lack of female treatment facilities. In May 2015, the only government-funded female treatment facility in the Western Cape was created from a formerly unisex facility. A psychologist at the facility noted that since becoming a female only facility, the treatment at this facility has not changed, thus failing to provide gender-specific treatment.

> Before [facility name] became an only female rehab, it was a rehab for both men and women. I think in the last year or year and a half it has changed to an all-female rehab and I don't know if it was thoroughly thought through or if it was thoroughly planned and prepared for. (F20)

The psychologist at this facility also noted that it is not only important that gender-specific treatment be provided but that treatment specific to pregnant coloured women should be made available.

> I think working with the pregnant women you would have to be more conscious and more aware of the patient because obviously your psychological health can have an impact on the baby. So I think you'd have to be more conscious and more self-aware, so yeah, I think that pregnant patients would need some different kind of treatment. Their emotions can affect the baby and can affect the mother as well. (F20^{2})

Similarly, the nurses reported that this facility does not accept pregnant females. If a female is pregnant she is told to wait out her term and return once the baby has been born. Nurses state that the only reason there are pregnant women in the facility is when they are admitted for substance abuse and discover that they are pregnant once they are already in the program.

> Most of the time, when they come, they don't even know that they are pregnant. They don't know the harm that they've been doing. So which means they've been smoking all along not realising in the first three trimesters is the critical period. (F19)

> Most of the time we never knew that person is pregnant. So they come here because of their substance abuse not because they are pregnant but no one ever complained about that you know? That it was a problem. So we just keep them. (F19^{2})

This indicates that it is difficult for women to access treatment. The trend in the study's data shows that even outpatient facilities predominantly treat males. Of the 20 healthcare providers interviewed, 18 provided services within outpatient facilities. Fifteen of those 18 outpatient healthcare providers noted that, even if their outpatient facility was fully equipped with all that they need for effective and comprehensive treatment, there would still be far fewer females accessing treatment.

> Look, I think it's that women don't even go to have themselves admitted and say 'I'm pregnant' and go for regular visits. They wait till they're going to have a baby now. Like you say, it's okay to want to implement a facility like that, it sounds ideal but again, there have been facilities that you mentioned that have run it, but the need for it has grown so excessively that the capacity that they have is not able to meet that.

> Then on the other hand you need to say, do you grow our problem by having comprehensive facilities? Already, it might not be relevant but there is a trend that young girls fall pregnant so that they can access grant money. (F12)

> We cannot control them because they are outside. When they are outside they can tell you, when they come in, they tell you 'Yes sister I'm on my medication, I'm fine and I'm not on drugs any more' but you can still see that this one maybe didn't take the treatment and this one didn't stop using TIK, this one is still continuing and all the signs are there. So actually the treatment outside is the problem. (F8)

4.3.1.2 Stigma. Of all the challenges that pregnant women face when accessing treatment, 19 out of 20 participants stated that stigma was one of the main causes for the low rate of pregnant women accessing treatment.

> Stigma is also one of the barriers because 'that one is talking about that one and what is that one doing here? Oh! She's coming here again! It's her second time!' or it's 'die vyfde kind! Kyk hoe sit die TIK monster alweer hierso' as they say. That makes that they really don't want to come to the clinic and she'd rather stay away; or she would come here a week before, or two or three weeks before she needs to give birth, then she will come in. (F9)

"I think it's the stigma. People look at you and say 'wow you're pregnant, what are you doing here at SANCA?' and they know that she is here for a drug problem" (F11)

> I think the community, as much as they may not intervene; they have an opinion of you that you are doing the wrong thing. They're not going to say anything to you. They're going to talk behind your back. They will have an opinion that this is not right so they get that kind of flack. (F12)

4.3.1.4 Transport affordability. Another outside influence that affects women accessing treatment is that of finding money for transport to facilities. Eleven healthcare providers reported that patients are unable to afford this.

> I even had one client, also a high risk client. She said 'sister I was supposed to be at Tygerberg that time but I didn't have money then, can't I come here?' Then what must you do? You must help. You can't turn them away. (F14)

> Most of the people who come here are unemployed and so the only way for them to get here is by walking, not many can afford public transport to get here. When we first started off we had bus vouchers and we could provide them to clients who tried and made it to group sessions. They just had to get to the bus stop and the bus dropped them right here. But we do not have access to those vouchers anymore. (M1)

4.3.1.5 Need too great for capacity. All the healthcare providers interviewed, from both the substance abuse and maternal sectors, report that the treatment that has been made available for treating substance abuse in general, is at full capacity. Treating females, let alone pregnant females, for substance abuse is already a challenge, with only one government-funded female facility existing in the Western Cape. Treating pregnant coloured substance abusing females proves an even more difficult problem to address. The psychologist at the only inpatient female facility in Cape Town noted that they can only accommodate 40 women at a time. Along with mentioning that there is a six month waiting list, she also reported that they have clients that come from as far as Worcester and George, which is up to 500km away.

"Some of our patients come from as far as Worcester uhm, as far as George so their families don't visit at all" (F20)

The outside influences that healthcare providers are not able to control were widely reported across all participants as structural barriers to treating pregnant women abusing TIK. Inclusively, the barriers experienced on the micro-, meso- and exo-systems levels appear to exist within an interactive larger system. Interestingly, 18 of the 20 participants mentioned communication with government as one of the most prominent overarching barriers to treatment. Similarly, all 20 of the participants identified funding as the most important solution to the problems they face when it comes to treating pregnant women abusing TIK, a problem that appears on a macro-system level.

4.4 The Macro-system

The macro-system setting embraces the institutional systems of a culture in which an individual exists including the economic, social, education, and political systems (Bronfenbrenner, 1979). Bronfenbrenner states that the effect of the macro-system on the lower systems can be seen by observing how the lower systems function (Rosa, & Tudge,

2013). It appears that the causes of the structural barriers experienced within the lower levels of analysis are contextualised in two themes, namely communication and funding.

4.4.1 Communication

Communication between healthcare providers and their representatives in government, i.e. those that make financial decisions regarding substance abuse and healthcare, is reported as ineffective. Seven participants reported feeling that the government does not understand the full extent of the crisis of substance abuse, not only amongst pregnant women but across the general population.

"Look, I feel that they don't know the extent of what we go through on a daily basis here at the facility. If they did know, yes I feel that would maybe allocate more resources and funding" (F17)

> You know if I can meet with Helen Zille or if I can meet with the president. I can meet with all of them that are sitting there at parliament and the two of us could tell them really, what substance abuse really is and how it's affecting our communities and our young children. I mean they don't see it really. (F11)

> I think people working on the ground or working with the clients are seeing certain trends. So you know, proposals are put out there for certain things that government feels that, drawing from their research or from wherever they compile that information, they're putting it into where they think best. Yet people working on the ground may feel otherwise. Let's say, into office there is an influx of youth but funding is given for something else. Why not then put in where the need is greater so that the funding can meet that? I also think that it creates a problem when the program that is being sponsored is not being met, you know in terms of funders wanting certain outcomes. (F12)

> I think they know it they just don't realise it. They can see the figures and the stats and studies but they don't realise that we are sitting with a big problem. Just referring to substance abuse; we are sitting with a major crisis. (M5)

Furthermore, the mere fact that there is only one female only facility in the Western Cape is representative of the government's lack of understanding regarding firstly, the rate of

substance abuse amongst women and, secondly, the low rate of women accessing treatment. A social worker at an outpatient facility mentioned this point at a conference in Durban; she found that there are many more government-funded female treatment facilities in other provinces

> I attended two workshops in Durban that was more gender based with specific focus on… I think it was the GROW program. I'm not sure if you know the GROW program, but it focused on the recovery of women, specifically women in treatment and women who are pregnant. Then when I was asked questions in my presentation on pregnancy, they were shocked because there was just no facilities. That time it was only [facility name] which has recently closed. So there are just no resources. If you look in other provinces, there's much more focus and funding on or for pregnant women and for normal women. So that is something in the Western Cape that is less focused on. (F6)

4.4.2 Funding. Discussing funding on the macro-system level concerns the effect of the decisions made by the Minister of Health and the Department of Social Development who do not have any direct contact with the healthcare providers in the field. The poor allocation of funding to treatment facilities, prominent in the reports of all 20 of the healthcare providers, is seen as a problem, together with the lack of staff and resources and infrastructural challenges within facilities.

4.4.2.1 Staff and resources. All 20 participants mentioned the continuing lack of staff as a barrier that they experienced to effective treatment.

"We are always short on staff. You end up getting frustrated because you must be here you must be there you must be all over. You must cut yourself in four to cover all the areas" (F9)

> What happens is the ladies come into the clinic and then we have to tell them that it is not the right day or they must wait and then they do not come back. We do that because we don't have enough staff to run every department every day. (F8)

> So, I don't know if there is something to do because it actually has more to do with… how can I say, inter-management. There are outside factors that come from outside the facility that can change out circumstances for the better. Unless you can give us a bigger hospital with 40% more staff. Bigger wards, sufficient staff, all equipment that

> we need and everything in working condition and if it breaks then we'd have replacements for it. (F10)

> I think, for me there are so many things I'm doing now. For example, having that support group for pregnant women, I wouldn't be able to do that even though I see the need, because there is just not enough staff. So I think structurally, I think we'd need more staff big time. That's what we would make things easier. (F13)

4.4.2.2 Infrastructure and space. Furthermore, 11 of the 20 healthcare providers reported that even if there were enough staff and specialised services available for patients, there is insufficient space within current facilities to allow for these services to be rendered.

> We already have a problem with infrastructure and that's why I cannot say this is the department for basic antenatal care. It's the same person that's doing the sick children who is assigned to doing basic antenatal care, you understand because we don't even have enough rooms to equip that room with a specific service. (F18)

"We do have a sick room, but it's a kitchen too. It's everything in one. We do have a bed there but it is so high and very uncomfortable" (F19)

Furthermore, one of the primary healthcare clinics servicing six suburbs in the surrounding area is only offering antenatal care once a week due to short staffing and infrastructural challenges.

"We can only give antenatal care one day a week because the space is too small and we do not have room" (F8)

Similarly, an administration and screening assistant reported that she conducts all screening and history documentation of walk-in patients in any office that is not being used at that particular time. If there are no offices available, she has to ask patients to return at a later stage, effectively losing potential patients.

"In terms of if offices are not available to use, then where do I see that person that is a walk-in client? We either have to ask them to come back on another day or they don't return" (F15)

4.4.2.3 Procurement. Thirdly, where funding is made available, there is a difficulty and lack of communication surrounding the procurement of those funds. Although only mentioned by 2 healthcare providers, it is an important issue for these facilities. A social worker reported not knowing where to apply for funding for factors such as contingency management as government does not have a specific vendor for this.

> The problem with funding, we've got the money, but the problem is kind of procurement. There are all these processes of getting stuff and that takes a while. Sometimes stuff that you need, they don't have specific vendors on the system, so we can't get the stuff because there are no vendors and we have to try look. (F13)

While the problem of procurement of funding was noted by 2 healthcare providers, six of the 20 participants mentioned that they would like to implement contingency management for their patients. This included a small incentive for milestones reached during treatment, fun educational outings, perhaps a small cup of soup before treatment for poverty-stricken patients or even bus passes to get to treatment. However, difficulties with procurement do not allow for this.

> So in that regard I feel that the funding is quite limited. In the past we sometimes took the patients to the ice rink and it was about socialising and having interpersonal skills where there isn't a budget for that now. That's too expensive to accommodate patients so where that is concerned I think there is a lack of funds. Yeah, there's not much you can do with R10 per patient. (F20)

> Well things like providing child care. What also works well, and that we can't currently do, is to provide food. For a lot of the people, they only have one meal a day or it is cold in winter, so having a hot cup of soup might be a good motivation and would help. (M1)

4.5 Conclusion

This chapter presented the findings of the present study, contextualising each theme within the micro-, meso-, exo- and macro-systems of the Social Ecological Theory. Each theme and sub-theme that was identified during data analysis was discussed and substantiated with corresponding quotations collected from semi-structured interviews with participants. The six main structural barriers to effective treatment that were experienced and reported by

the healthcare providers interviewed included overburdened and under-resourced healthcare providers, the referral system and its effect on healthcare providers' work and home life, external influences outside of the healthcare providers' control and communication with government and funding. In the chapter to follow a discussion on these findings will be presented.

Chapter 5: Discussion and Conclusion

5.1 Introduction

This chapter will present an integration and discussion of the themes and sub-themes that were identified and highlighted through the process of data analysis in the previous chapter. An interactive narrative will be presented that discusses the link between the themes and sub-themes of this study as seen through the perspective of Bronfenbrenner's Ecological Systems Theory (1979) on the one hand, and current literature on the other. Following this, the limitations of the present study will be outlined then recommendations will be offered for future research surrounding structural barriers experienced by healthcare providers for pregnant coloured women abusing TIK. Lastly, the chapter will end with a conclusion and take-home message.

5.2 Findings, theoretical framework and literature

There have been numerous studies conducted in South Africa that show that TIK abuse during pregnancy is on the rise (Jones et al., 2011, 2014; Onah et al., 2016; Petersen Williams et al., 2014; Plüddeman, Myers, & Parry, 2008; Williams, 2014). Compared to the rise in the prevalence of TIK abuse amongst pregnant coloured women in the Western Cape and specifically in Cape Town, the anticipated rise in the treatment of these women is minimal (Jones et al., 2011; Wechsberg et al., 2008). Furthermore, there are many South African studies that highlight the barriers to treatment that pregnant women and substance abusers experience; barriers that hinder them from accessing both maternal and substance abuse treatment (Myers et al., 2010; Myers & Parry, 2005; Myers et al., 2014). Similarly, there are several South African studies that focus on previously disadvantaged communities and their struggles to access healthcare and substance abuse treatment (Myers, 2007; Rispel, 2015). Fewer studies however, have focused on the structural barriers that South African citizens' experience when accessing healthcare for HIV/AIDS and TB treatment (Coetzee et al., 2011; Myers et al., 2008). To date, there have been no studies that focus, from the healthcare providers' perspective, on the structural barriers to treatment, specifically when treating pregnant coloured TIK abusing women. The present study was thus conducted in light of this gap in research.

The rate of TIK abuse in coloured communities in Cape Town is the highest in the world (Jones et al., 2011; Plüddemann et al., 2008; United Nations Office on Drugs and

Crime, 2015; Watt et al., 2014). With the side effects of increased libido, elevated confidence and weight-loss, TIK abuse amongst the coloured female population in Cape Town has increased dramatically (Plüddeman et al., 2008; Watt et al., 2014). Most likely as a result of promiscuous behaviour due to the effects of TIK, coloured women abusing TIK often fall pregnant and find themselves unable to discontinue their TIK abuse (Jones et al., 2011). Although pregnant coloured women abusing TIK may attempt to reduce their TIK abuse, the addictive nature of the drug makes this difficult without professional treatment (Jones et al., 2011; Myers, Louw, & Fakier, 2008). This study thus focused on healthcare providers in the Cape Town area who are confronted with structural barriers when treating pregnant coloured women abusing TIK.

In accordance with the present study's first research objective noted in chapter three, in section 3.4 semi-structured interviews allowed for the structural barriers experienced by the healthcare providers in this study to be unpacked. Although these structural barriers are unique, there are some similarities between those found in the present study and those found in studies on structural barriers to healthcare in South Africa and abroad. For example, the sub-theme of stigma amongst patients accessing treatment was also found in a study by Coetzee et al. (2011) that focused on structural barriers to HIV treatment in South Africa. Furthermore, the sub-theme of staff shortages and the theme of communication and funding challenges accord with the study of Myers et al. (2008) on the structural barriers to treatment for historically disadvantaged communities in Cape Town. Additionally, the sub-theme of infrastructural challenges to treatment was also apparent in Ntembi's (2010) study focussing on the factors hindering the treatment of individuals that abuse substances in Nairobi, Kenya. However, novel barriers found within the present study that pertain specifically to the treatment of pregnant coloured women abusing TIK, are clearly indicated.

Themes and sub-themes within the present study, were established through an analysis of the data and were contextualized using Bronfenbrenner's (1979) Ecological Systems Theory. Each theme and sub-theme was contextualized and discussed within its respective level of the Ecological Systems Theory including the micro-, meso-, exo- and macro-systems (Bronfenbrenner, 1979). Furthermore, the themes and sub-themes are linked to associated studies and their findings, including but not limited to those mentioned above. It is important to note that many of the participants that were interviewed reported that their interactions with pregnant coloured women abusing TIK were minimal. However, the

majority (90%) of the participants reported that the majority of the patients that they treat are coloured.

A discussion of each of the micro-, meso-, exo- and macro-systems containing the most prominent themes and sub-themes that were established through data analysis will follow. Each theme discussed serves as a structural barrier to treatment that healthcare providers experience when treating pregnant coloured women abusing TIK.

5.2.1 Micro-system

The micro-system is described by Bronfenbrenner (1979) as the system in which the individual interacts and takes part in direct proximal interaction with other individuals. Bronfenbrenner placed emphasis on the psychological aspects of the individuals present in the immediate setting in the micro-system (Paquette & Ryan, 2001).

5.2.1.1 Overburdened and under-resourced

a) Burnout. There are a number of studies that highlight burnout as a key problem for healthcare providers within the behavioural and medical health professions. Oser, Biebel, Pullen, & Harp (2013) report that burnout is experienced the most within the human service industry due to the emotional aspect within the provider-client relationship. Healthcare providers are thus at risk for burnout within the demanding micro-system that is the workplace. Burnout was reported by almost all of the participants (95%) in the present study as a result of high volumes of patients that need to be attended to, the nature of the treatment provided, pressures due to short-staffing and the fulfilment of roles outside their job description and/or professional training.

The provision of maternal as well as substance abuse treatment was reported by the majority of participants (85%) as psychologically and physically exhausting, affecting all aspects of the treatment that they provide. According to Shoptaw, Stein, & Rawson (2000), burnout is a concept described by a three-dimensional scheme that consists of emotional exhaustion, depersonalization and lack of personal accomplishment. Healthcare providers experience difficulty with empathy and expressing compassion for patients (Shoptaw et al., 2000). Emotional exhaustion and depersonalisation of patients among healthcare providers results from a lack of support triggered by staff shortages and high caseloads (Shoptaw et al., 2000). Detachment and disengagement from patients' emotional needs is noticeable in the

reports of participants discussing patients being scolded and stigmatized by nurses for abusing TIK during their pregnancy. All the participants in the present study had experienced a sense of lack of accomplishment at some stage in their professional tenure, further exacerbating depersonalisation and emotional exhaustion.

b) Motivation and despondence. Both substance abuse and medical healthcare providers in the present study experienced despondence as a direct result of a low sense of accomplishment within their field. This despondence which triggered poor staff morale was mentioned by 65% of participants. Thus poor staff morale and a low sense of accomplishment impacted negatively on treatment style and efficacy and reduced the quality of the services rendered. This finding coincides with Myers' (2007) study that focused on access to treatment for historically disadvantaged communities. She found that high caseloads, the struggle to meet the demand for treatment, and the sense of being over-burdened have contributed to the rate of frustration and feelings of low job satisfaction amongst healthcare providers.

Consistency is vital for building a trustful relationship with a client and for creating the foundation for positive treatment retention (United Nations Office on Drugs and Crime, 2004). For healthcare providers, heavy caseloads simply do not allow for the building of trust between patients and healthcare provider. One participant explained it clearly by comparing her daily treatment of patients to a production line, where, in trying to treat as many patients as possible, one is forced to focus on quantity and not quality. On the other hand, ten substance abuse treatment providers specifically reported that they have sufficient time to treat patients, but that their patients are often unwilling to admit to their problem of substance abuse, are manipulative, are implicated within the criminal justice system, and possess little motivation to remain in treatment. Oei et al. (2011) similarly found in their study on drug dependency during pregnancy that motivation for substance abuse treatment was only found in those participants who were fearful that Child Protective Services would take their child away if they did not receive treatment. The abovementioned factors affect the consistency of treatment that the healthcare providers in this study can offer, which, in turn, diminishes the efficacy of the treatment provided by them.

c) Treatment style and efficacy. Evidence from studies conducted in the USA found that healthcare facilities that are well-resourced in terms of staff are able to provide a large range of services in a more effective manner, thus increasing the efficacy of the treatment

provided (Lemak, Alexander, & D'Aunno, 2001; Olmstead, White, & Sindelar, 2004). Although not a prominent theme in the present study, Myers et al (2008), noted in their study on access to substance abuse treatment for previously disadvantaged communities, that staff turnover, due to burnout and frustration was high, and this impeded treatment efficacy. While staff turnover was mentioned by only 2 participants in the present study, major staff shortages were emphasised by all participants which arguably could be the key contributor to burnout amongst healthcare providers.

It is evident from the preceding discussion that healthcare providers experience a number of barriers that result from feelings of being overburdened and working in an under-resourced environment. It is clear that the barriers within the micro-system exist in circular sequence. Staff shortages and minimal availability of treatment time are what cause maternal treatment to be time-pressured and also prevent healthcare workers spending as much time as they need to comprehensively treat their patients. Rushed treatment slots often result in failure to detect TIK abuse during pregnancy when patients fail to disclose this abuse. This was also found by Oei et al. (2011) where participants were found to hide their drug abuse during pregnancy in fear of their children being removed from their care.

On the other hand, where healthcare providers offering substance abuse treatment have sufficient time for treatment sessions, the focus of treatment revolves largely around motivating patients to remain in treatment. Healthcare providers in the substance abuse sector are aware of the rate of relapse amongst individuals abusing substances in general, as well as the high rates of relapse amongst pregnant coloured women abusing TIK. Despite this, the rate of job satisfaction remains low. In their study on burnout amongst substance abuse counsellors, Oser et al. (2013) found that such counsellors are at a high risk for burnout due to their clients' lack of motivation to change, which is a source of frustration and low job satisfaction. Healthcare providers experiencing burnout with no support provide treatment with a negative outlook, which, in turn, can negatively affect other aspects of their lives. It is thus also important to understand how the micro-systems within which healthcare providers exist, affect and are affected by one another. The section to follow will reflect on the themes that emerged within the meso-system.

5.2.2 Meso-system

The meso-system, defined by Bronfenbrenner (1979), as the interaction between the micro-systems in which an individual exists, includes, in this case, a healthcare providers' work setting and home setting. Barriers in one micro-system negatively impact other micro-systems within the lives of healthcare providers (Bronfenbrenner, 1994). The interactions between healthcare providers' micro-systems within the work place as well as between the workplace and home life informed the themes for this level of analysis. According to the *White paper for the transformation of the healthcare system in South Africa, Notice 667* (1997), in order to create a comprehensive and integrated national health system, defragmentation of health services at all levels and effective referral systems at the primary, secondary and tertiary levels of health care need to be implemented (Mkhize & Kometsi, 2008). Furthermore, access to these services needs to be increased, with special focus on rural and peri-urban communities and with an emphasis on vulnerable groups, for example pregnant women (Government Gazette, 1997).

5.2.2.1 Referral

a) Referral within facilities. In 2008, substance abuse treatment services were incorporated into primary healthcare clinics across the Cape Town area, through the implementation of the Matrix Model (Gouse et al., 2016b). Pregnant substance abusing women's access to this treatment however, remains low; with participants at most Matrix sites reporting an 80 – 20% ratio of males to females; two per cent of which being pregnant females. The 2016 review of the implementation of the Matrix Model in primary healthcare settings reported interesting findings that accord with the findings of this study. Although there is no focus on pregnant substance abusing women specifically, the 2016 report noted that treatment retention levels are low, as was noted by 80% of the participants in this study. Furthermore, the 2016 report noted that focus should be brought to implementing motivational based programs to improve this (Gouse et al., 2016a). Motivation as a barrier was mentioned by all 10 of the substance abuse healthcare providers interviewed within the present study. This relates to the aforementioned barriers reported by substance abuse healthcare providers, i.e. spending much of their treatment time with patients motivating them to complete the program. This begs the question: why are the rates of access amongst pregnant coloured women abusing TIK and treatment retention levels low?

In their study investigating the views of healthcare providers about screening and brief interventions for pregnant women abusing substances treated at MOU's in Cape Town, Williams et al. (2015) found similar barriers to those found in the present study. Within healthcare facilities that do not offer in-facility substance abuse treatment, such as MOU's, tertiary hospitals and day hospitals, current treatment for women abusing substances during their pregnancy involves a lack of formal protocol around confronting and addressing the associated risks (Williams et al., 2015). Current protocol within MOU's and tertiary and day hospitals, involves emotional support, motivation and health education surrounding the risks involved with substance abuse during pregnancy (Williams et al., 2015). However, as with the present study, Williams et al. (2015) noted that the majority of midwives and nurses faced with pregnant women abusing substances are not equipped for or trained in the field of substance abuse (United Nations Office on Drugs and Crime, 2004). Thus, they have to refer pregnant women abusing substances to social workers and counsellors for further evaluation and education.

b) Fragmentation of services. The problem of referral, however, specifically that concerning treatment of pregnant women abusing TIK, is prominent amongst maternal healthcare providers. The referral system within and between healthcare facilities poses a problem to accessing the services that pregnant substance abusing women are in need of (Isobell et al., 2015). Within Matrix sites, referral within facilities appears useful, as women can access both maternal treatment as well as substance abuse treatment in one setting. However, pregnant women who present for basic antenatal care and who are found to be abusing substances are classified as high-risk, treatment for which Matrix sites cannot provide. Pregnant women abusing substances are subsequently referred to the Matrix section of the clinic for substance abuse treatment as well as to the nearest MOU or hospital that provides treatment for high risk pregnancies.

Sorsdahl et al. (2012) evaluated the effectiveness of a hospital-based intervention for patients abusing substances and yielded promising findings. Of the 127 participants, 55% felt that the program met their needs and it was concluded that the screening and brief intervention and referral to treatment (SBIRT) program would make it easier for reducing substance abuse and expanding access to care (Sorsdahl et al., 2012). However, 88% of participants were male and it is unclear if any female participants were pregnant at the time. Furthermore, high-risk patients were still referred to specialist substance abuse treatment

centres (Sorsdahl et al., 2012). The findings in this study, as in that of Sorsdahl et al. (2012) present a smooth referral for pregnant women within the Matrix facilities from the maternal section to the substance abuse section and vice versa. The problem, however, reported by 100% of participants within the present study, arises when patients are referred to alternate healthcare facilities due to the high risk nature of their pregnancy. In other words, when they are referred to facilities that do not offer substance abuse treatment.

The 10 substance abuse healthcare providers that made up 50% of the 20 participants reported that they cannot guarantee the return of these patients to the Matrix facility, thus exacerbating low treatment retention amongst females abusing substances during their pregnancy. Similarly, the same findings were found to occur within the SANCA facilities (Burnhams et al., 2015). Healthcare providers at SANCA do not expect pregnant patients that are referred to MOU's and hospitals for high risk care to return for out-patient substance abuse treatment. This is indicated in the reports of two healthcare providers who assert that pregnant women abusing substances would rather access maternal treatment than substance abuse treatment. The preference for maternal over substance abuse treatment is found to be due to various factors outside of healthcare providers' control. This is later discussed in section 5.2.3 addressing the exo-system level barriers. Nonetheless, it remains a barrier to comprehensive treatment and is experienced within the meso-system of the workplace.

c) Delay in services due to protocol. In addition, the problem of referral between facilities creates the secondary barrier of delays in accessing services due to protocol. The United Nations Office on Drugs and Crime (2004) found that pregnant women are generally refused access or not given priority admission to substance abuse treatment. For patients that are to be referred for inpatient substance abuse treatment, gaining access to gender-specific treatment in a government-funded all-female facility is a lengthy process. Pregnant women abusing TIK in the Cape Town area have various obstacles to overcome before they can gain access to an inpatient facility (United Nations Office on Drugs and Crime, 2004). The only government-funded female inpatient facility in Cape Town can house just 40 patients at a time. Two healthcare providers at this treatment facility report that the waiting list for a treatment slot is as long as 6 months. This coincides with Myers (2007), who confirmed equally long waiting lists to access in-patient treatment facilities in Cape Town. Nearly a decade later, nothing has been done to rectify or improve the lengthy waiting period to gain access to treatment.

Furthermore, participants from this facility report that they require extensive documentation before a patient can be put onto a waiting list. They note that, in order to gain access, the facility requires an intake report from a social worker and a full medical report from a nurse. This proves too strenuous a process to follow for pregnant women abusing substances and many of them do not complete all the steps to gain access to this facility. Furthermore, the participants in this study report housing a number of pregnant patients even though they are not supposed to admit pregnant women to the facility for treatment. While many participants within the out-patient facilities are under the impression that this facility rejects pregnant patients, pregnant patients referred to this inpatient facility by outside healthcare providers are told to wait out the term of their pregnancy and then reapply (United Nations Office on Drugs and Crime, 2004). Pregnant patients that are accepted into the in-patient female facility had only discovered that they were pregnant once already admitted to the facility. The delays caused not only by protocol, but by lack of communication and awareness between facilities regarding services rendered is reason for concern. If healthcare providers are not aware of what services are rendered at such a specialised facility, i.e. the only government-funded female facility in Cape Town, the rate of access to treatment by pregnant coloured women abusing TIK will remain insignificant.

5.2.2.2 Home life. The interactions between the many micro-systems within the workplace have been found to extend into healthcare providers' home lives (Ericson-Lidman & Strandberg, 2010). Directly related to the theme of being overburdened and under-resourced described in section 5.2.1.1, the effect of burnout on healthcare providers' home life is placed within the meso-system because the micro-system that is the home life is affected by the micro-system that is the work place through burnout. The pressures and draining interactions within their work setting are reportedly 'taken home' by healthcare providers. With seven participants reporting 'taking home' workplace pressures, the findings in this study resemble the findings of Ericson-Lidman & Strandberg's (2010) study. They found that family members and close-friends of healthcare providers experiencing burnout reported feeling constrained, insecure, weary of the sufferers behaviour and tired and disappointed (Ericson-Lidman & Strandberg, 2010). Furthermore the themes highlighted in their study involved participants trying to change the healthcare providers' thinking patterns by reaffirming their skills as healthcare provider and practicing setting limits in both their private lives and in the workplace (Ericson-Lidman & Strandberg, 2010). The psychological, physical and mental wellbeing of healthcare providers experiencing burnout is compared to

that of depression (Ericson-Lidman & Strandberg, 2010), and perpetuates the depersonalization of and detachment from patients that serves as a barrier to treatment.

Similarly, in this study participants noted feeling drained after a working day and that work demands shortened and negatively affected their time with their families. Participants also reported exhaustion and struggles with a low immune system, causing them to fall ill often. This perpetuated their struggle with motivation within the workplace, negatively affecting their treatment style and treatment efficacy. The interacting micro-systems of the workplace and home life appear to form a harmful cycle, where each micro-system affects and is affected by the other.

It is clear that the barriers highlighted within the healthcare providers' meso-system are interconnected. The effects of interacting micro-systems reach further into other areas of healthcare providers' workplace and personal life. The next section will focus on the exo-system level and the associated barriers to treatment.

5.2.3 Exo-system

The exo-system influences both the meso- and micro-systems without any direct contact or interaction with the healthcare provider (Bronfenbrenner, 1979). For example, healthcare providers have no control over the infrastructure of their work place. Infrastructural barriers negatively affect their interactions with patients and their treatment efficacy.

5.2.3.1 Healthcare providers cannot control outside influences. The lack of control over outside influences that affect access to treatment and treatment retention among patients was one of the most prominent themes that emerged during the interviews with 100% of participants in this study. The main factors outside of healthcare providers' control are noted by participants: 18 of 20 (90%) participants mentioned the drug-abusing environment; 19 out of 20 participants (95%) mentioned the stigma associated with substance abuse during pregnancy; 11 of 20 (55%) noted the lack of money for transport and 14 (70%) mentioned the lack of government-funded female treatment facilities available in Cape Town.

5.2.3.1 Drug-abusing environment. Of the 20 healthcare providers, 18 mentioned the fact that they cannot control the outside influences that may affect the patients' motivation and ability to remain in treatment. It appears that the drug abusing environment

makes it difficult for pregnant coloured women abusing TIK to both access and remain in treatment. Coupled with the voluntary nature of treatment, pregnant coloured women abusing TIK are within environments that exacerbate TIK abuse. For example, they could be living with an individual abusing TIK such as a partner or family member.

5.2.3.2 Women accessing treatment. The majority (90%) of the healthcare providers in the present study noted their inability to mobilise pregnant coloured women abusing TIK to voluntarily access treatment for their substance abuse and cited stigma as the most significant cause of this.

a) Stigma. Two healthcare providers, who live in coloured communities, conveyed that even though community members are aware of the TIK abuse problem and recognise some community members as 'TIK monsters', the stigmatisation of pregnant coloured women abusing TIK is the most prominent. Recent studies have found that as a result of the stigma attached, it is frowned upon for pregnant coloured females to seek substance abuse treatment that would reveal this substance abuse during their pregnancy (Isobell et al., 2015: Myers et al., 2009; Stone, 2015; Wechsberg et al., 2008). Interestingly, the rate of accessing maternal treatment by pregnant coloured women abusing TIK is higher than that of accessing substance abuse treatment; a difference that is indicative of their preference for maternal treatment. Healthcare providers report that even those pregnant females that have been referred for substance abuse treatment under law sanctions, still do not attend treatment. They will attend one session, to receive their confirmation of enrolment document and never return for treatment.

It appears that the issue of stigma is focussed more on accessing substance abuse treatment and less on maternal treatment. Only once children have been removed from the pregnant substance abusing woman's care, is there a higher rate of substance abuse treatment access and retention, but not always (Isobell et al., 2015). The voluntary and, at times, even involuntary nature of treatment creates a barrier for healthcare providers. There is no way to effectively mobilise pregnant coloured women abusing TIK to access the treatment that they need.

b) Transport affordability. A second factor outside of healthcare providers' control, reported by 55% of participants, is the problem of transport. Patients cannot afford transport to access substance abuse and maternal treatment across different facilities. The socio-

economic status of pregnant coloured women abusing TIK does not allow for transportation money to be spent on travelling between healthcare facilities (Myers et al., 2008). A pregnant coloured woman abusing TIK, unable to afford transport, can reportedly walk more than 30km to access the clinic that serves her area. Combined with the dangers of gang wars and passing drug addicts and dealers en-route to the facility, many of these women decide against accessing treatment. This has also been found in a similar study on the potential barriers to the use of health services among ethnic minorities, where facilities in unsafe environments posed a threat to treatment access and retention (Scheppers, 2006).

In questions that posited an ideal scenario and a solution to the problem of fragmentation of services, healthcare providers were asked to share their thoughts about establishing a comprehensive treatment centre with both maternal and substance abuse facilities in one building. Interestingly, although not a prominent finding within the present study, a minority (40%) of healthcare providers responded with a pessimistic viewpoint towards this notion. Two healthcare providers mentioned that even though services could be accessed under one roof, the stigma and voluntary nature of treatment would persist and may not necessarily increase treatment access and retention. Furthermore, one participant questioned whether creating such a facility would indirectly condone TIK abuse during pregnancy within the coloured community and make TIK abuse during pregnancy more acceptable.

c) Need too great for capacity. A third factor reported by all 20 healthcare providers is that of the lack of government-funded, inpatient female substance abuse treatment facilities. Furthermore, all 20 participants report that demand for these facilities far outweighs the current capacity for treatment. The shortage of funding has contributed to the deficit in female substance abuse facilities in Cape Town, a macro-level theme that will be discussed in section 5.2.4. The effects of this shortage of treatment centres however, are placed within the exo-system as they indirectly affect healthcare providers' effective treatment. Access to treatment among pregnant coloured women abusing TIK in Cape Town is minimal and the fact that there is only one female-only government funded treatment facility available in Cape Town possibly plays a key role in this. Even this facility does not provide maternal treatment, as mentioned in section 5.2.2.2, and can only house 40 patients. It is thus unable to accommodate the profuse need for the treatment of pregnant coloured females abusing TIK

and those that are accommodated continue to experience fragmented services, seeking maternal treatment outside this inpatient facility.

Healthcare providers in the present study note that the rate of access to treatment is minimal due to an array of outside influences over which they have no control. These factors include stigma, issues with transport affordability and safety and the lack of government-funded female treatment facilities in Cape Town. In the final section (to follow), the overarching themes of communication and funding, noted by all participants as the chief contributors to the micro-, meso- and exo-system level barriers, will be discussed.

5.2.4 Macro-system

The macro-system, involves the culture in which individuals live and is referred to as the sociocultural context (Bronfenbrenner, 1979). The effect of the macro-system on the lower systems can be seen through the success or failure of the lower systems' functioning (Rosa, & Tudge, 2013).

5.2.4.1 Communication. Although communication was mentioned by only seven of the 20 participants (35%), it is an important macro-level barrier to consider when addressing the structural barriers to treating pregnant coloured women abusing TIK. Participants reported that without consulting with healthcare providers who experience barriers to treatment on a daily basis, government officials possess limited knowledge of what these healthcare providers need. Participants in Myers et al. (2008) study reported similar communication barriers, stating that the government's failure to collaborate with the Alcohol and Other Drug Strategy (AOD) abuse treatment providers, diminishes the government's ability to effectively address substance abuse problems.

The 2014-2017 AOD strategy put forward by the City of Cape Town (2014), includes strategic changes based on the shortcomings of the 2011 strategy. The 2011 strategy was criticised for its lack of internal knowledge regarding its implementation (City of Cape Town, 2014). Within the new strategy, it was proposed that sphere coordination would facilitate collaboration with role players and stakeholders in the prevention and intervention process. Interestingly, two years into the implementation of the new strategy, healthcare providers continue to report a lack of knowledge on the part of officials who have the final say on strategies that address the substance abuse problem in the Cape Town area. Furthermore, the monitored and evaluated impacts proposed as strategic change do not appear to have been

taken into consideration considering the current paucity of treatment centres for females and more specifically coloured pregnant females in Cape Town (City of Cape Town, 2014).

The 2014 Alcohol and Other Drug strategy also addresses interventions for high risk individuals (City of Cape Town, 2014). For treating high risk individuals, training and the support of City Health and Social Development and Early Childhood Development Directorate (SDECD) staff to increase literacy around mental health was to be implemented. Additionally, empathetic care and trauma support was to be applied and brief mental health screening tools that assess for stressors and risk factors was to be encompassed in the patient's records. Finally, the establishment of uninterrupted referral paths for alternate services such as social and legal services that included both professionals and non-specialists was to be created and provision was to be made for more support for families and youth that are identified as high risk (City of Cape Town, 2014). This final point was to serve as an attempt to reduce stigma and increase the identification of high risk patients (City of Cape Town, 2014).

It is commendable and appropriate that the latest AOD strategy took factors associated with high risk patients into consideration. However, under current circumstances, the implementation of these strategies has proved to be challenging. Noted in section 5.2.1.1, healthcare providers in general, as well as those who treat high risk patients, are overburdened and pressed for time. Including elements such as brief mental health screening tools and further support for families and high risk youth into treatment is not feasible under the healthcare providers' current time constraints. Short staffed facilities that give rise to rushed treatment slots simply do not allow for extra individual treatment, mental health screening and family support. Furthermore, with the current infrastructural challenges mentioned in section 5.2.4.2, there is no space to offer an extra service such as family support. The incorporation of new strategies may have assisted health providers to treat the patients that have accessed treatment more comprehensively, but those patients that haven't face longer waiting times and may never reach treatment.

Liaison with departments within the City of Cape Town responsible for the AOD strategy is vital to communicate this. First and foremost, all 20 healthcare providers in this study are in need of more staff to effectively implement strategies set up by government. Although there are strategies to train social workers to develop action plans for addressing AOD abuse in their area as well as funding allocated to the training of nurses by the DoH,

this does not seem to address the need for more healthcare providers on site. Group interventions for pregnant coloured women abusing TIK may prove a feasible solution to the problem of staff shortages, as suggested by eight participants in this study. An evidence based study conducted on alcohol, cannabis and methamphetamine use amongst black and coloured women in the Western Cape showed that through group-intervention for females, it is possible to reach at-risk women from poorer communities in a cost-effective manner (Wechsberg et al., 2008). However, where it has not yet been implemented, participants noted that even if they wanted to incorporate women's support groups, they do not have the staff or the infrastructure to do this.

The Western Cape Department of Health (DoH) Minister, Dr Nomafrench Mbombo, noted in his 2016 speech that the public hearings for the Western Cape Health Facility Boards and Clinic Committees Bill have been set in motion (Mbombo, 2016). The aim of this bill is to place active citizenry between health facilities and the community in the hope of placing ownership of the health system in the hands of the community (Mbombo, 2016). It is through this bill that budget decision-making and employment of staff is devolved to facility managers on the ground that can identify the needs unique to the communities accessing their treatment facilities. Optimistically speaking, once the bill has been passed and accepted, its implementation may assist to address the problem of communication between healthcare providers in the field and government members making budget allocation decisions.

Although amended strategies of collaboration have been introduced into the AOD plan for 2014 - 2017, it is clear that there remains a gap in the collaboration with healthcare providers over what is necessary for the effective treatment of pregnant coloured women abusing substances in Cape Town. With the Western Cape Facility Boards and Clinic Committees Bill, this problem could potentially be addressed. However, the decision made by facility managers on site to employ more staff is met with infrastructural challenges. Thus, the overarching and most prominent barrier to treatment that all 20 participants felt would solve most, if not all of their problems if addressed, is that of funding.

5.2.4.2 Funding. The Western Cape Department of Social Development (DoSD), responsible for addressing the problem of substance abuse, has received a budget of R1,96 billion for the period of 2015/16. Of this budget, R98, 9 million is allocated to substance abuse, prevention and rehabilitation programs (Fritz, 2016). Compared to the R535 million allocated to crime prevention and victim empowerment programs; the R149 million allocated

to services for people with disabilities and the R204 million allocated to poor and older citizens, the smallest allocation of the provincial budget has been assigned to substance abuse (Fritz, 2016). The DoSD Minister, Albert Fritz, noted in his 2016 budget speech that the department's aim is to match the demand for treatment for substance abuse with a sufficient supply of substance abuse services. More specifically, the DoSD Minister noted the strong continuation of the female only, inpatient treatment facility and program.

In creating an even balance between supply and demand for treatment of pregnant coloured women abusing TIK in Cape Town, all participants reported that the demand outweighs the capacity of the one female facility available in the city. Not only has limited funding resulted in a paucity of affordable and accessible treatment centres in Cape Town, but 95% of healthcare providers have also mentioned the structural barrier of lengthy waiting periods for patients to access treatment. Similarly, for the existing outpatient substance abuse facilities funded by the DoSD, the funding has not kept pace with the growing demand for treatment. Evident from the findings of this study and also reported by 100% of participants, is the fact that the barriers of staff shortages, scarce availability of resources, and infrastructural difficulties are the effects of the macro-level barrier of funding.

a) Staff and resources. Conveyed by all of the present study's participants, the trickle-down effect of government decisions regarding allocation of funding has produced barriers that directly and indirectly affect the participants' ability to provide effective treatment on all levels. With R27,3 billion of the national budget for healthcare allocated to training healthcare providers, staff shortages reported within medical and substance abuse treatment facilities remain high (National Treasury, 2016). Additionally, participants noted that funding for resources and equipment such as pregnancy tests and gynaecological test sets at out-patient facilities such as SANCA may reduce the need for referral to MOU's and hospitals and could lessen the travel costs experienced by pregnant coloured women abusing TIK. Similarly, maternal staff within primary healthcare clinics indicated that if they have sufficient training and equipment to treat high risk patients, the fragmentation between maternal and substance abuse services could be resolved. There have been strategies implemented by government to strengthen primary healthcare by including more services within the facilities, however, the efficacy of these endeavours is minimal.

b) Infrastructure and space. When the national health insurance grant was introduced in 2012, the aim was to strengthen primary healthcare by the effective

implementation of national health insurance for all South Africans (*National Treasury*, 2016). In the 2016 budget review however, the ten pilot sites selected to test the primary healthcare strengthening interventions proved ineffective and had little impact (*National Treasury*, 2016). Thus, the national health insurance grant, with a baseline of R85million, will be discontinued in the 2016/17 financial year. The reasons for its conclusion will be presented in a close-out report in 2017. The national health insurance indirect grant will replace the national health insurance grant, with the DoH allocating funding on behalf of each province. The national health insurance indirect grant that was implemented in 2013 consisted of 5 components, namely health facility revitalisation, contracting health professionals, human papilloma virus vaccine, ideal clinics and information systems. The national health insurance indirect grant allocation is R4, 7 billion (National Treasury, 2016).

Participants noted that the allocation of more funding from the DoH would potentially result in the employment of more staff and the acquisition of more resources, thus affording more effective treatment. However, 55% of the participants in the present study report that infrastructural challenges cause the problem of a limited amount of space being available to accommodate more staff and resources. Since 2013, the first component of the national health insurance indirect grant has seen progress, revitalising facilities such as Community Day Centres (CDC's), a paediatric ward and a psychiatric unit. However, except for one facility that was visited in Ravensmead (where a new reception area was being built); no infrastructural changes have been made to primary healthcare sites that offer both maternal and substance abuse treatment.

c) Procurement. Although procurement of funding was only mentioned by 2 of the 20 (10%) participants in the present study, the accessibility of funds that are available should flow smoothly in order to avoid the perpetuation of funding as a barrier to treatment. Participants report not being able to procure funds for contingency factors such as soup for patients during winter and small incentives to mark milestones in their treatment process. Contingency management, based within the concept of operational conditioning in behavioural psychology, has been found to promote continuance of positive behaviour regarding treatment when certain stages of treatment have been successfully completed (Wright, Schuetter, Fombonne, Stephenson, & Haning, 2012). With no specific vendors on the system that healthcare providers use to apply for the procurement of funding, they are unable

to afford aspects of contingency management, thus losing out on opportunities of possible improved treatment outcomes with their patients.

5.3 Limitations

There are three leading limitations to this study which are important to consider. Firstly, two of the semi-structured interviews were conducted with more than one participant at a time. The reason for this was that the participants at this facility were pressured by time constraints. One participant was called out of the interview on two occasions. However, reports of barriers by one participant seemed to elicit accounts of similar experiences from the other participants as they were able to build on each other's reports and describe these barriers in greater detail. The second interview, consisting of two participants, included their clinic representative at the City of Cape Town, who requested to be present in the interview. It appeared that the participants within this particular interview were wary of honestly and openly expressing their struggles within the facility. This may have been due to the presence of their clinic representative.

Secondly, although the participants differed in demographic features such as age, gender, profession, years of experience and the site where healthcare is provided; the participant group was not fully representative of the broader population of healthcare providers that treat pregnant coloured women abusing TIK. This was due to the fact that permission to conduct interviews at MOU's, CHC's and institutions such as tertiary and psychiatric hospitals in Cape Town, was granted late in the research process, when interviews with participants as well as data analysis had been completed. This is important to take into consideration when interpreting the findings of the present study as participants were only located at PHC facilities, out-patient substance abuse facilities and at a tertiary hospital. However, data was collected up to the point of data saturation where no new themes emerged. It was upon data saturation that I decided, in consultation with her supervisor, that it was not necessary to continue with data collection at the newly approved sites.

Thirdly, the themes that emerged within thematic analysis of the data were not verified by the participants. In order to ensure that the accounts of healthcare providers were interpreted correctly, preliminary themes that were construed from the interview data could have been sent to participants to be verified. Alternatively, emerging themes could have been discussed with participants within focus groups. Unfortunately, due to the limited time

available to participants and the difficulty of coordinating the time available for discussions, it was impossible to verify emerging themes. Furthermore, the distance to treatment facilities posed a problem regarding access to the participants more than once. To account for this, during interviews, I made use of member checks to ensure that her interpretation of what healthcare providers were saying was correct so that misinterpretation could be avoided.

5.4 Recommendations for future research

The present study has created opportunities for future research on the structural barriers that healthcare providers experience when treating pregnant coloured women abusing TIK in Cape Town. The first and possibly most important recommendation for future research would entail the potential development and implementation of strategies that address these structural barriers. Furthermore, to gain more insight into the barriers to accessing treatment, a study focusing on structural barriers from the patients' perspective could be conducted.

Regarding limitations surrounding the generalisation of findings, future research could replicate this study to include participants from MOU's, CHC's and tertiary and psychiatric hospitals. Furthermore, future research could explore the possible difference in structural barriers experienced in these facilities compared to those utilised in the present study, namely, PHC facilities, outpatient substance abuse treatment facilities and a tertiary hospital. Additionally, a replicated study could include facilities from broader South Africa in order to investigate whether healthcare providers everywhere experience the same kind of barriers and also to increase the generalisability of the findings.

Furthermore, while TIK abuse and TIK abuse during pregnancy is most prevalent in the Coloured community of Cape Town, future studies could be broadened and applied to all racial categories of South Africa. Even though the Coloured racial group is well represented in the Western Cape, future research could be informed by the fact that TIK abuse during pregnancy affects all social groupings.

Future studies could also evaluate the efficacy of the current AOD strategy for 2014-2017 and investigate how the problem of structural barriers to treatment in general and specifically for pregnant coloured women abusing TIK could be addressed. The findings could inform policies developed by the Department of Health, Department of Social Development and the City of Cape Town in order to make substance abuse treatment and

maternal treatment more accessible within one facility. Lastly, future research should promote the strengthening of the current referral system and find the best ways to do so to address the gap in the referral system specifically pertinent in the treatment of pregnant Coloured women that abuse TIK.

5.5 Conclusion

The present study aimed to explore the experiences of healthcare providers who encounter structural barriers to the treatment of pregnant coloured women who abuse TIK in Cape Town, South Africa. This exploratory qualitative study exposed a number of structural barriers to treatment including overburdening of healthcare providers, under-resourced staff and facilities, challenges with the referral system, factors outside healthcare providers' control that affect access to treatment, communication barriers and shortages of funding. These themes were contextualised through the application of Bronfenbrenner's (1979) Ecological Systems Theory, and correlated to the existing literature on barriers to treatment from a healthcare providers' perspective (Coetzee et al., 2011; Kalichman, Kalichman, & Cherry, 2015; Myers et al,2008). It was clear that most of the themes highlighted in this study were consistent with the findings of existing studies on healthcare providers' experiences of the structural barriers to treatment for individuals with other disorders such as HIV/AIDS and tuberculosis. This could suggest that barriers that are experienced by healthcare providers who treat pregnant women abusing TIK could be similar to the barriers experienced by healthcare providers treating individuals with other conditions.

Although the themes that emerged in this study are consistent with previous findings on the barriers to treatment experienced by healthcare providers, it was found that the novel barrier hindering the effective treatment of pregnant coloured women abusing TIK is the referral system. The findings of this study suggest that there is a gap in the referral process that exacerbates the low access rates to substance abuse treatment during pregnancy. This gap in the referral system was found to affect, and be affected by various factors including fragmentation of services and transport affordability, thus serving as structural barriers to the treatment of TIK abuse during pregnancy.

With the paucity of inpatient female substance abuse facilities in Cape Town, pregnant coloured women abusing TIK are required to access substance abuse treatment within PHC and outpatient treatment facilities. As these women are regarded as a high risk

group, they are in need of specialised treatment which PHC and outpatient facilities are not equipped to provide. Ironically, the very clinics into which substance abuse treatment has been integrated are unable to treat high risk pregnant coloured women abusing TIK. These women are thus referred to MOU's and hospitals that are equipped to provide high risk care but do not offer substance abuse treatment. In other words, the facilities that offer substance abuse treatment cannot provide the high risk maternal treatment that pregnant coloured women abusing TIK need, and the facilities that offer high risk maternal treatment, do not offer substance abuse treatment. This gap in the referral system has subsequently resulted in the fragmentation of services for pregnant coloured women abusing TIK.

The integration of the Matrix substance abuse treatment model into PHC facilities aimed to address the fragmentation of physical healthcare treatment and substance abuse treatment. Although the introduction of the Matrix model into PHC facilities has yielded positive results in reducing the rate of substance abuse within communities, the inability to treat high risk pregnant coloured women abusing TIK has reduced the number of these women accessing substance abuse treatment at PHC facilities. The effort to avoid fragmented service provision by combining healthcare and substance abuse treatment has thus not reached the population who need it.

Accordingly, these women need to access maternal and substance abuse treatment at more than one facility. They are often not able to access treatment on both platforms due to the problem of transport affordability. As a result, and the related literature shows this, preference is given those seeking maternal treatment over substance abuse treatment (Jones et al., 2014; Oei et al., 2011). Pregnant coloured women abusing TIK thus access maternal treatment at clinics, MOU's and hospitals that can provide high risk treatment, however, the lack of substance abuse treatment within these facilities possibly perpetuates the abuse of TIK during pregnancy. The need for substance abuse services within facilities that can treat high risk pregnant coloured women abusing TIK has thus emerged. Alternatively, PHC facilities need to be equipped with the resources to treat this vulnerable group. This however, may prove to defeat the very essence of primary healthcare, which is to provide the most basic healthcare to patients.

The findings of this study have achieved the research objectives of uncovering the structural barriers to treatment experienced by healthcare providers when treating pregnant coloured women abusing TIK, showing how these structural barriers hinder effective

treatment and outlining what is needed for comprehensive treatment. This study is one of the first of its kind in South Africa and the findings within the present study serve as a platform for future research on this particular subject. Furthermore, it is hoped that at policy level as well as at ground level, these findings will inform the creation and implementation of interventions that eradicate structural treatment barriers for pregnant coloured women abusing TIK as experienced and reported by healthcare providers.

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List of Appendices

The following documents are attached and included in support of the present research study

A. Ethical Clearance

B. Permission Letters

C. Biographical Questionnaire

D. Informed Consent Form

E. Semi-Structured Interview Questions

F. Participant Profiles

G. Turnitin Report

Appendix A: Ethical Clearance

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Approved with Stipulations

New Application

19-Feb-2016

Nagel, Jodi JB

Proposal #: SU-HSD-001867

Title: **Structural barriers to providing comprehensive healthcare to pregnant TIK abusers from coloured communities in Cape Town: The experiences of healthcare providers**

Dear Miss Jodi Nagel,

Your **New Application** received on **10-Feb-2016**, was reviewed
Please note the following information about your approved research proposal:

Proposal Approval Period: **19-Feb-2016 -18-Feb-2017**

The following stipulations are relevant to the approval of your project and must be adhered to:
The researcher may proceed with the envisaged research provided that the following stipulations, relevant to the approval of your project are adhered to or addressed. Some of these stipulations may require your response. Where a response is required, you must respond to the REC within six (6) months of the date of this letter. Your approval would expire automatically should your response not be received by the REC within 6 months of the date of this letter.

If a response is required, please respond to the points raised in a separate cover letter titled "Response to REC stipulations" AND if requested, HIGHLIGHT or use the TRACK CHANGES function to indicate corrections / amendments of ATTACHED DOCUMENTATION, to allow rapid scrutiny and appraisal

INSTITUTIONAL PERMISSIONS

The researcher indicates that she will select health care practitioners involved in treating TIK abusing pregnant mothers from the following health care facilities, rehabilitation facilities and health care clinics in and around Cape Town. These include:

Valkenberg Psychiatric Hospital in Observatory; Cape Town, Kensington Clinic, in Tafelsig; Mitchells Plain; SANCA treatment centre in Bellville, Mitchells Plain and Tygerberg; Badisa in Bellville and Stikland Opiate Detox Unit in Bellville.

Formal institutional permission is required from the Provincial Department of Health as well as from the Superintendents of the specific facilities. The researcher must submit copies of letters granting institutional permission as soon as these are obtained from the institutions and facilities.

Please provide a letter of response to all the points raised IN ADDITION to HIGHLIGHTING or using the TRACK CHANGES function to indicate ALL the corrections/amendments of ALL DOCUMENTS clearly in order to allow rapid scrutiny and appraisal.

Please take note of the general Investigator Responsibilities attached to this letter. You may commence with your research after complying fully with these guidelines.

Please remember to use your **proposal number (SU-HSD-001867)** on any documents or correspondence with the REC concerning your research proposal.

Please note that the REC has the prerogative and authority to ask further questions, seek additional information, require further modifications, or monitor the conduct of your research and the consent process.

Also note that a progress report should be submitted to the Committee before the approval period has expired if a continuation is required. The Committee will then consider the continuation of the project for a further year (if necessary).

This committee abides by the ethical norms and principles for research, established by the Declaration of Helsinki and the Guidelines for Ethical Research: Principles Structures and Processes 2004 (Department of Health). Annually a number of projects may be selected randomly for an external audit.

National Health Research Ethics Committee (NHREC) registration number REC-050411-032.

We wish you the best as you conduct your research.

If you have any questions or need further help, please contact the REC office at 218089183.

Included Documents:

DESC Report
REC: Humanities New Application

Sincerely,

Clarissa Graham

REC Coordinator

Research Ethics Committee: Human Research (Humanities)

Appendix B: Permission Letters

CITY OF CAPE TOWN
ISIXEKO SASEKAPA
STAD KAAPSTAD

CITY HEALTH

Dr Hélène Visser
Manager: Specialised Health

T: 021 400 3981 F: 021 421 4894 M: 083 298 8718
E: Helene.Visser@capetown.gov.za

2016-04-25

Re: Research Request: Structural barriers to providing comprehensive healthcare to pregnant tik abusers from coloured communities in Cape Town: The experiences of healthcare providers (6620) (ID No: 10564)

Dear Ms Nagel,

Your research has been approved as per your request.

Khayelitsha Sub District: Contact People	Site B Clinic Dr V de Azevedo (Sub District Manager) Tel: (021) 360-1258/ 083 629 3344 Mrs S Patel Abrahams (Head: PHC & Programmes) Tel: (021) 360-1153/ 084 405 6065
Mitchells Plain Sub District: Contact People	Tafelsig Clinic Mrs S Elloker (Sub District Manager) Tel: (021) 391-5012/ 084 222 1478 Mrs N Nqana (Head: PHC & Programmes) Tel: (021) 391-0175/ 084 2221489
Tygerberg Sub District: Contact People:	Ravensmead Clinic Mrs M Alexander (Sub District Manager) Tel: (021) 938-8279 / 084 222 1471 Mrs D Titus (Head: PHC & Programmes) Tel: (021) 938-8281 / 084 308 0596
Western Sub District: Contact People:	Albow Gardens Clinic Mrs G Sifanelo (Sub District Manager) Tel/Cell: (021) 514-4122 / 084 630 2903 Mrs M Stanley (Head: PHC & Programmes) Tel/Cell: (021) 514-4124 / 072 329 6361

Please note the following:

1. All individual patient information obtained must be kept confidential.
2. Access to the clinics and its patients must be arranged with the relevant Managers such that normal activities are not disrupted.
3. A copy of the final report must be sent to the City Health Head Office, P O Box 2815 Cape Town 8001, within 6 months of its completion and feedback must also be given to the clinics involved.
4. Your project has been given an ID Number (10564). Please use this in any future correspondence with us.
5. No monetary incentives to be paid to clients on the City Health premises.

Thank you for your co-operation and please contact me if you require any further information or assistance.

Yours sincerely

DR G H VISSER
MANAGER: SPECIALISED HEALTH

cc. Mrs Sifanelo & Mrs Stanley
Mrs Elloker & Ms Nqana
Mrs Alexander & Mrs Titus
Dr de Azevedo & Mrs Patel Abrahams
Ms L Bosch

Western Cape Government
Health

TYGERBERG HOSPITAL
REFERENCE: **Research Projects**
ENQUIRIES: **Dr GG Marinus**
TELEPHONE:**021 938 5752**

Ethics Reference: **SU-HSD-001867**

TITLE: Structural barriers to providing comprehensive healthcare to pregnant tik abusers from coloured communities in Cape Town: The experiences of healthcare providers.

Dear Miss Jodi Nagel

PERMISION TO CONDUCT YOUR RESEARCH AT TYGERBERG HOSPITAL.

1. In accordance with the Provincial Research Policy and Tygerberg Hospital Notice No 40/2009, permission is hereby granted for you to conduct the above-mentioned research here at Tygerberg Hospital.

2. The research is also approved on condition that the proposed 40-60 minutes interviews will be conducted outside working hours as doing so during working hours has potential to affect the operations negatively.

3. Researchers, in accessing Provincial health facilities, are expressing consent to provide the Department with an electronic copy of the final feedback within six months of completion of research. This can be submitted to the Provincial Research Co-Ordinator (Health.Research@westerncape.gov.za).

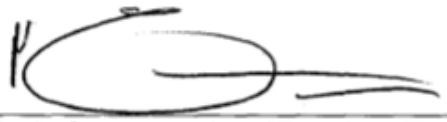
DR GG MARINUS
MANAGER: MEDICAL SERVICES [RESEARCH CO-ORDINATOR]

DR D ERASMUS
CHIEF EXECUTIVE OFFICE
Date: 6 May 2016

TYGERBERG HOSPITAL

Ethics Reference: **SU-HSD-001867**

TITLE: Structural barriers to providing comprehensive healthcare to pregnant tik abusers from coloured communities in Cape Town: The experiences of healthcare providers.

BY 

An authorized representative of Tygerberg Hospital

NAME Dr DS Erasmus

TITLE CEO

DATE 6 May 2016

Appendix C: Biographical Questionnaire

Biographical Information

Please note: *The researcher will endeavour to take every care to ensure your anonymity. No identifying information will be made available to any other participant in this study or reader thereof unless you indicate otherwise. Dr Chrisma Pretorius, the supervisor of this project, may however request permission to use the questionnaires to further the research about the structural barriers that healthcare providers face when treating coloured women that abuse TIK while pregnant and related studies, at which time you will have the right to decline the use of this information in further research*

		Specifically identifiable information that you wish to remain confidential
Name		
Surname		
Title		
Age		
Gender		
Ethnicity	African / Coloured / White / Other……..	
Home language	Afrikaans / English / Xhosa / Zulu Other……..	
Email address		
Contact number		
Highest level of qualification		
How long have you been a healthcare provider?		

…… …… ……	
Do you specialise in any field? …… …… …….. **How long have you been involved in substance abuse treatment?** …… …… ……. **How long have you been involved with treatment of pregnant substance abusers?** …… …… …….	

Appendix D: Informed Consent Form

UNIVERSITEIT•STELLENBOSCH•UNIVERSITY
jou kennisvennoot • your knowledge partner

STELLENBOSCH UNIVERSITY
CONSENT TO PARTICIPATE IN RESEARCH

Structural barriers to treatment for pregnant Coloured women abusing TIK in Cape Town: the experiences of healthcare providers

REFERENCE NUMBER: SU-HSD-001867
PRINCIPLE RESEARCHER: Jodi Nagel
ADDRESS: 136 Fairfield North Street, Parow North, Cape Town, 7550
CONTACT NUMBER: 082 707 5313

Dear Healthcare Provider

You are asked to participate in a research study conducted by Jodi Nagel, from the Psychology Department at Stellenbosch University. Results from this study will contribute to thesis research. You have been invited to participate in this study because you have been identified as a healthcare provider that is or has been involved in the treating of women who abuse/abused TIK while pregnant and have experienced barriers hindering your ability to provide effective treatment.

Please ask the researcher any questions about any part of this project that you do not understand. It is very important that you are fully satisfied that you clearly understand what this research entails and how you could be involved. Your participation is **entirely voluntary** and you are free to decline to participate. If you decline to participate, this will not affect you negatively in any way whatsoever. You are also free to withdraw from the study at any point, even if you do agree to take part.

This project has been approved by **the Research Ethics Committee at Stellenbosch University** and will be conducted in strict accordance with the ethical guidelines and principles of the South African Guidelines for Good Clinical Practice and the Medical Research Council (MRC) Ethical Guidelines for Research.

1. PURPOSE OF THE STUDY

The proposed study aims to elucidate structural barriers that healthcare providers face that hinder treatment of pregnant women abusing TIK. The proposed study posits that by underlying the structural barriers, the information acquired will possibly assist in the designing of strategies to make comprehensive obstetric and substance abuse treatment available and effective for pregnant women abusing TIK.

2. PROCEDURES

If you volunteer to participate in this study, we would ask you to do the following things:

- Complete a once-off semi-structured interview that will last approximately 40-60 minutes, during which you will talk about your experiences and frustrations regarding the structural barriers hindering your ability to provide effective substance abuse treatment to pregnant women abusing TIK.

A semi-structured interview will be conducted at a time and place that is most suitable to you. The semi-structured interview will consist of questions that relate to your experiences and regarding the structural barriers hindering your ability to provide effective treatment to pregnant women abusing TIK.

I (a Stellenbosch University Psychology Masters student) will conduct the interviews on a one-on-one basis. Each interview will be approximately 40-60 minutes long. With your permission, the interview will be audio-recorded so that it can be transcribed verbatim for the data analysis. You, as the participant, retain the right to review/edit all recordings.

3. POTENTIAL RISKS AND DISCOMFORTS

The proposed study can be classified as low risk. Even though the research will be conducted on a largely controversial topic, is not likely to cause you discomfort. You, as the participant, are not considered to be part of a vulnerable research population. The research will compose of information that can be regarded as non-sensitive, such as experience and opinion rather

than personal information and will be collected anonymously through semi-structured interviews.

4. POTENTIAL BENEFITS TO SUBJECTS AND/OR TO SOCIETY

There will be no direct benefit or remuneration for taking part in this study. However, this study is one of the first of its kind in South Africa, and it is thus possible that the findings of this study could be published as a scholarly article in a peer-reviewed journal. This could lead to a greater understanding of the structural barriers experienced by healthcare providers that hinder effective treatment delivery to women who abuse TIK during pregnancy.

5. PAYMENT FOR PARTICIPATION

You will not be paid to participate in this study; participation is voluntary and you will not be reimbursed for their participation.

6. CONFIDENTIALITY

Any information that is obtained in connection with this study and that can be identified with you will remain confidential and will be disclosed only with your permission or as required by law. Confidentiality will be maintained by means of assigning a code instead of using the participant's name. You will have the right to review/edit audio recordings of interviews. Only the researcher and her supervisor will have access to the information obtained during the study. All the collected data will be kept secure in a locked cabinet in the researcher's office and it will be appropriately destroyed and discarded after 5 years, once the study is completed. No confidential or identifying information will be used. Biographical information will only be used to generate descriptive statistics.

7. PARTICIPATION AND WITHDRAWAL

You can choose whether to be in this study or not. If you volunteer to be in this study, you may withdraw at any time without consequences of any kind. You may also refuse to answer any questions you don't want to answer and still remain in the study. The investigator may withdraw you from this research if circumstances arise which warrant doing so, although it is not anticipated that any circumstances can arise that would warrant such withdrawal.

8. IDENTIFICATION OF INVESTIGATORS

If you have any questions or concerns about the research, please feel free to contact the Principal Investigator: Jodi Nagel 082707513 or Supervisor: Dr. Chrisma Pretorius on 021 808 3435.

9. RIGHTS OF RESEARCH SUBJECTS

You may withdraw your consent at any time and discontinue participation without penalty. You are not waving any legal claims, rights or remedies because of your participation in this research study.

If you have questions regarding your rights as a research participant, contact Ms Marléne Fouché
[mfouche@sun.ac.za; 021 808 4622] at the Division for Research.

SIGNATURE OF RESEARCH SUBJECT OR LEGAL REPRESENTATIVE

By signing below, I, _____ agree to take part in a research study entitled **Structural barriers to providing comprehensive healthcare to pregnant TIK abusers from coloured communities in Cape Town: The experiences of healthcare providers**

I have read or had read to me this information and consent form and it is written in a language with which I am fluent and comfortable.

- I have had a chance to ask questions and all my questions have been adequately answered.
- I understand that taking part in this study is voluntary and I have not been pressurised to take part.
- I may choose to leave the study at any time and will not be penalised or prejudiced in any way.

Signed at (place) _____ on (date) _____ 2016.

Signature of participant Signature of witness

_____ _____

SIGNATURE OF INVESTIGATOR

I (name) _____ declare that:

□ I explained the information in this document to _____

□ I encouraged him/her to ask questions and took adequate time to answer them.

□ I am satisfied that he/she adequately understands all aspects of the research, as discussed above

□ I did not use an interpreter.

Signed at (place) _____ on (date) _____2016.

Signature of investigator Signature of witness

_____ _____

Appendix E: Semi-structured Interview Questions

Interview Questions

1. What is your background and experience in the field of healthcare?

2. Tell me a about your work and experiences with women who abuse TIK during pregnancy?

3. What is the general age that your patients begin using TIK?

4. What is your opinion regarding treatment of women who abuse TIK during pregnancy?

5. What do you think would be the most effective way of dealing with women who abuse TIK during pregnancy?

6. What are in your opinion the main challenges that health care professionals face when dealing with women who abuse TIK during pregnancy?

7. Of those, what would you say is the most prominent barrier stopping you from treating women who abuse TIK while pregnant?

8. What would you consider to be the most effective treatment for women who abuse TIK during pregnancy?

a. Availability of this in South Africa?

b. Access?

9. What makes it easier (or will make it easier) for you as a health care professional to deal with women who abuse TIK during pregnancy?

10. What are in your opinion, are the main challenges faced by women who abuse TIK during pregnancy?

11. What do you think makes it easier (or will make it easier) for women to access treatment for their TIK abuse during pregnancy?

12. Any final thoughts?

Appendix F: Participant Profiles

Warren (M1)

Warren is a 36 year old student at UCT, currently completing his masters in psychiatry. He is employed full-time as a facility manager and has been involved in substance abuse treatment for 12 years. My interview with Warren was my first and I was nervous. He spoke quickly and gave dense answers that contained a lot of information. He mentioned that his dealings with pregnant coloured women abusing TIK are minimal, but still gave me valuable insight as to the barriers that pregnant coloured women experience when accessing their facility.

He seemed to take a while before realising that my study was from his perspective, and therefore did not list as many structural barriers as I had hoped. Perhaps because he is the facility manager and does not treat patients anymore he was not aware of the structural barriers to treatment at the facility. I realised throughout the interview that I did not gain too much relevant data from Warren, but I was still able to use some of his answers. Fortunately, I was able to arrange two interviews with his colleagues, Chrystal and Leigh-Anne

Chrystal (M2)

The day I had to meet Chrystal I had to wait in the waiting room for an hour. At first I was nervous to sit in between patients waiting to see her, but once I had chatted to some of them I felt at ease. Chrystal is a 30 year old social-worker and was very helpful. She was able to answer all of my questions easily. She appeared passionate about pregnant women abusing TIK and spoke the longest on the question regarding the reasons that her patients begin using TIK. Compared to my interview with Warren, this interview was more relaxed and we laughed a few times.

There were some difficulties as the facility was noisy and people interrupted by knocking on the door, however, the recording remained clear. It was half way through Chrystal's interview that Leigh-Anne came in, who said she was available to join in the discussion.

Leigh-Anne (F3)

Leigh-Anne's interview was cut short because she joined in the middle of Chrystal's interview, so the questioning carried on from that point. However, the first few questions were not about the crux of my study, i.e.: the structural barriers. Thus, I was able to get relevant information from Leigh-Anne too. She is a 31 year old social worker who had just given birth 1 year earlier. I felt a little overwhelmed when both of them spoke at once with different experiences, but it seemed that their reports of what went on in the facility triggered experiences within one another, improving their memory and detailing their experiences more.

Leigh-Anne told me about her negative experience with preeclampsia and how she was rushed to hospital 2 weeks before she was due with kidney failure. She had an emergency caesarean and was very ill for week s after that. That was when she told me about the difficulties that they have at the facility. I felt excited that I had gathered valuable information from both Chrystal and Leigh-Anne and felt more confident in my interviewing skills.

Garetha (F4), Edrich (M5) and Corne' (F6)

The interview with Garetha, Edrich and Corne' was like a group discussion. Garetha is 64, the oldest participant I interviewed and spoke English with an Afrikaans accent. She is a white woman that has been working as a nurse for 34 years. Edrich, a young white registered counsellor, was the participant that spoke most in the meeting. Both Garetha and Corne, when answering questions referred to Edrich as if he had more appropriate answers. It was clear that they had respect for him and his knowledge even though he was only 25 years old. Corne', a 34 year old coloured social worker was the participant who had dealt with pregnant coloured women abusing TIK the most at her facility. All three participants were very friendly and had a lot to say. Edrich was called out of the interview twice for a phone call and for a patient. Immediately, upon his return, Corne' relayed the question that she was busty answering to him.

I had approached this facility a month prior to our meeting as a month later was the first time all three of them had a space in their schedule. It just so happened that this free time fell on the same day for all 3 of them, and Garetha thus suggested combining the interview. She made a copy of the interview questions and all three of them had prepared some answers

in advance. This is what made the interview like a discussion, almost a focus group, where they built on each other's opinions and experiences. This was one of the most informative interviews that I conducted. The perspective of a nurse and social worker and a counsellor all at once gave a broad picture of the barriers they experienced at their facility.

Sister Parker (F7)

I approached this facility without having made any appointments. No participants were returning my emails or telephone calls so I decided to drive there. I was helped by a very friend admin clerk who pointed me in the right direction, to all three of the nurses' offices. Unfortunately the social worker only came on in Wednesdays and Fridays. I arrived on a Monday morning. When he showed me to Sister Parker, a 61 year old coloured psychiatric nurse, I was surprised to find that she was in a container behind the facility. I immediately noted this as an infrastructural challenge. When I knocked on the door, she was busy with a patient so I waited approximately 15 minutes. When I entered and introduced myself and asked her if I could ask a few questions she said she had no time. Immediately after that she asked me what it is about and I used the opportunity to ask her a few of the questions. Since her next patient was late, she said I should sit down.

Even though the container was cramped and 5 people were at work inside, she gave me vital information. She was probably the most frustrated and passionate participant when I came to telling me about the barriers she faces on a daily basis. She focused very much on how she did not sign up to be a psychiatric nurse to only treat TIK abuse. She also focused heavily on the fact that she feels she is fighting a losing battle when it comes to TIK abuse in her community. In her 30 years of experience as psychiatric nurse, she said that the last 5-8years, she has become extremely despondent, because the majority of her day consists of treating individuals that abuse TIK and at times, they became violent towards her. It was clear that she appreciated the space to air her frustrations. We spoke for about 10 minutes after the interview was complete about ways to address the problems that she mentioned.

Sister Williams (F8)

I struggled slightly with Sister Williams. As a 51 year old coloured nurse that has been working as a nurse for 30years, she was not able to answer many of my questions. Those questions that she could answer however were very short. I was able to gain some valuable information from her, but it appeared that she did not quite understand the questions

I was asking. I therefore switched over to Afrikaans and the interview started to flow better. I was puzzled that she is a qualified burse that reported only a matric certificate as her highest level of education. Furthermore, the facility that she was at was relatively new and only offered antenatal services once week. However, she was able to report that their equipment is insufficient and that they do not have allocated space for the antenatal treatment, making it difficult. She also stated that because the antenatal treatment is only available once a week, mothers that come on a different day that are unaware the treatment is available only once a week are turned away and told to come back on the day that it is available. She said that often these women do not come back to the facility.

Sister Wessels (F9)

All three Sr. Parker, Sr. Williams and Sr. Wessels were located at the same facility. I was able to see Sr. Parker and Sr. Williams directly after one another, but because Sr. Wessels works in the children's' section of the clinic that day, she was very busy and thus told me to come back that Friday when it is less busy. Sister Wessels, a 48 year old coloured nurse focussed on her frustration with mothers that abuse TIK during their pregnancy. She noted that, on more than one occasion, she has mothers coming in with their 3rd or 4th pregnancy. She states that even though she tells them the dangers and almost scolds them for their TIK abuse during pregnancy, they do not stop.

Sr. Wessles was the participant that used quite a bit of coloured dialect in her interview and it was refreshing. It appeared as a true depiction of what the coloured community may think of pregnant coloured women abusing TIK

Sister Voigt (F10)

Sister Voigt is a 29 year old coloured midwife. She was more comfortable conducting the interview in Afrikaans. She was extremely passionate about her job. When I brought up possible shortcomings and barriers within her facility she seemed to mention some, but immediately after state a positive fact about the facility. She reiterated many times that even if she is tired or the only midwife on shift attending to 34 women at a time, she signed up to help people so she cannot complain. I was able to get some information regarding their referral system that posed as quite a significant barrier to treatment, as well as the fact that her ward does not see the totality of pregnant coloured women abusing TIK. This is because she works in the maternity ward and she reported that many of the pregnant women that abuse TIK go straight into the labour ward upon admission.

Sr. Voigt provided thick descriptions of the barriers and reasons for them, as well as positive counters for every barrier that she mentioned. Her interview was one of the longest to transcribe and yielded valuable information.

Sister Brown (F11)

Sister Brown works at an outpatient facility in Athlone. She is a coloured, 60 year old nurse with 42 years of experience in the field. My interview with her was the longest of the 20 interviews conducted. We were uninterrupted in the 45minutes that we spoke. She was extremely passionate about both her patients and her colleagues. She noted funding as the most prominent barrier within their facility. The fact that there are sponsors that allocate funding to the wrong projects provided her a source of frustration. She stated that the influx of youth that is abusing TIK has the lease amount of funding allocated to it within their facility. She was also one of the 2 healthcare providers that mentioned procurement of funding for contingency factors as a barrier. She noted that her patients that received tokens of achievement for reaching goals within their treatment program responded better compared to those patients that did not receive goal reaching tokens.

Sr. Brown also felt sympathetic to her social worker colleagues and mentioned that they no longer felt that they were dealing with social issues such as domestic violence and child abuse. The majority of their cases are TIK abuse. Furthermore, she was very concerned about the miscommunication between government and healthcare providers like herself. She spoke about wanting to speak to Helen Zille about the crisis of substance abuse not just in her area but the whole of Cape Town. She focused less on specific lower level structural barriers and highlighted the macro-system level barriers of funding and communication.

Cheryl (F12)

Cheryl is a 43 year old coloured social worker who had come into the facility on the day that I had interview Sr. Brown, to come and collect her possessions left in her office. She was one of the social workers that had resigned a few weeks earlier due to the very reasons Sr. James reported. She that she no longer felt that she was treating social work related cases, just TIK abuse. She felt tired trying to motivate her patients to complete the program and from patients that do not return after a number of sessions. She is one of the participants that appeared the most despondent. She has been working in the field of social work for 12 years, and reported that after 3 years at this facility; she is tired of the TIK abuse problem.

She described the crisis of TIK abuse in general through ‘a ball of string’ analogy. She explained that it is like trying to untangle a knotted ball of string. Every time you solve one problem, pulling at one end of the ball of sting, it tightens another end, creating or exacerbating another problem associated with TIK abuse. She also seemed despondent on the macro-system level, where she countered my suggestions to solve the problem with more problems. It seemed that she had lost all hope of ever solving or even addressing the problem of TIK abuse in pregnancy and TIK abusing in general.

Samba (F13)

Samba, a 32 year old black qualified social worker, currently completing her masters specialising in substance abuse care, spoke softly and slowly. She felt that it is difficult to mobilise pregnant women to

seek treatment of their substance abuse which is why her interaction with pregnant TIK abusing women are minimal. She mentioned programs within their community that do women’s outreach projects to treat them where they are at. She did however speak about one pregnant patient in particular, that made it quite far in the program but moved back in with her boyfriend and restarted active abuse.

She almost shifted ‘blame’ toward the clinic section of the facility when we were speaking about waiting times. She reiterated on more than one occasion that their substance abuse section had eradicated waiting times, but patients struggled with long waiting times on the clinic side.

Samba focused a lot on the fact that staff is limited at their section of the facility and that if they had to incorporate a group therapy session for pregnant women abusing TIK, that there would be nobody to facilitate it because they all have their hands full. Furthermore, she was the second participant to mention procurement due to a lack of vendors on the system when applying for funding. Like Sr. Brown, she spoke about the positive reinforcement associated with tokens for goals reached in the recovery process. Overall, Samba seemed sympathetic to pregnant coloured women abusing TIK, reacting positively to comprehensive treatment facility posed as a solution to the problem of TIK abuse during pregnancy amongst coloured women.

Sister Klaasen (F14)

Sister Klaasen is a 36 year old coloured nurse, trained to work in all of the sections of her facility, including child care, maternal care, tending to the sickly in general and even assisting in emergency cases. Upon waiting for Sr. Klaasen, she was inside the emergency room and told me she would be out in a moment. She had just spent the last 2 hours trying to resuscitate a 6month old baby who had arrived earlier that morning with her grandmother from the Eastern Cape.

When we began the interview she was sombre. Once we had been speaking for a few minutes, she seemed to feel better. She was very friendly and although well-spoken, used coloured dialect in her reporting of the barriers that she encounters on a daily basis. This made the interview fun and we found ourselves laughing on more than one occasion. She also, like Sr. Voigt, seemed to counter every barrier that she mentioned with a positive aspect or a reason for why she should not complain. At the same time however, it appeared that she appreciated the platform to voice her frustration. She mentioned that a few weeks earlier, the government conducted a survey on the staff to patient ratio in their facility. They allocated one admin clerk to their facility, saying that their staff numbers are sufficient. She noted that all of the staff members at their facility felt overburdened and that the demand does not decrease at all. She compared their daily treatment to a production line, where they focus on quantity and not quality, just to get all of the patients treated that day. Of all of the participants, Sr. Klaasen seemed the least worried about taking time out of her busy schedule, which is ironic because she seemed to be one of the busiest of all the participants.

Candice (F15), Zakia (F16) and Natasha (F17)

Candice is an administrative assistant at her facility, booking in and conducting the overall history reports of patients. She is a 33 year old white woman, with 16 years of administration and history taking experience. Zakia is a 28 year old coloured counselling psychologist who completed her internship year at the facility and has been employed there for 3years. Natasha is a 38 year old coloured social worker who been working in the social work field for 10years.

Upon beginning the interview, all 3 participants seemed slightly uncomfortable. It was only after being introduced to their facility representative in government that I became

aware that she had requested to sit in on the interview. As the questioning began, they seemed to relax because the initial interview questions were centred on their general experiences as healthcare providers and their interaction with pregnant coloured women that abuse TIK. It was when the structural barriers within the facility came about that Zakia and Natasha became more reserved. After Candice noted that awareness of the treatment they offer and infrastructural challenges for history taking served as structural barriers, both Natasha and Zakia seemed hesitant. With one or two probing questions that focused more directly on specific possible structural barriers, they were able to answer with yes or no and then elaborate further.

It was clear that they were both carefully working their answers, almost intimidated by their government representative. Natasha mentioned that she felt that if government had a better idea of their experiences in the field on a daily basis they would more appropriately allocate funding, but then countered that with a positive note about funding. It did not impinge on the information provided by these two participants, but rather on the full explanation and frustration around the barriers that they faced.

Lizl (F18)

Upon entrance into the facility, I was shown to Lizl's office. She was just walking out of a meeting with an auditor who was there to do the annual audit of the facility. She thus seemed stressed and pressed for time, but remained helpful as we had arranged this date and time for the interview. My interview with Lizl, a 38 year old coloured nurse, employed as a facility manager, was brief. She mentioned that because she no longer treats patients that she is unable to describe her experiences with pregnant coloured women abusing TIK. However, she was able to report some barriers within the facility. As Lizl did not treat patients, the barriers that she mentioned were on a macro-level. She noted infrastructure, funding and admin as barriers within the facility that, if addressed, could improve the access to and quality of treatment. I was worried that because my interview with Lizl was so short, that I would not have gathered enough information from her. However, upon listening to the recording at home, I found that she had explained her experiences of barriers within the facility well.

Sister Aziza (F19)

When I arrived at my interview with Sr. Aziza, a 56 year old coloured nurse, she informed me that was not in a very good space as she was fasting and had forgotten to eat before sunrise that day. She said she was tired. This perhaps added to the fact that she was emotional about the closing of her facility in two weeks' time and she would be out of work for the first time in 40 years. As she was tired and emotional, I had to ask probing questions to get to the information that I needed. Nevertheless, she was able to provide valuable information regarding the barriers that she encountered on a daily basis. Sr. Aziza appeared to have a caring treatment style, stating that she believed in giving hugs, even though it was not received well or condoned by her colleagues at the facility.

She noted the cold treatment style as the most prominent barrier to treatment in the facility. She described one incident where a patient was in tears and threatening suicide. All other healthcare providers kept their distance and made sure she could not commit suicide. Sr. Aziza however, went to the patients and held her as she cried. She said that after that, the patient felt better and went back to her room.

Stacey (F20)

A 29 year old, coloured psychology master's student, Stacey was quite formal and well-spoken in her interview. She was platonic and answered interview questions in a non-disclosing manner, almost as if she did not want to implicate herself in reporting shortcomings of the facility. However, when it came to reporting structural barriers, she described her experiences with these barriers on a daily basis in a manner that I was able to make use of member checks to determine if my interpretation was correct. Stacey's interview took place on a Friday afternoon, when most of her administrative work was completed. She asked if she could eat her lunch during her interview as she had not had time to eat that day. She was the only one to mention having a family member who abused TIK. She described that when she sees patients that are abusing TIK during their pregnancy, she is reminded of that family member, but does not let it affect her treatment negatively.

Appendix G: Turnitin Report

Structural barriers to treatment for pregnant Coloured women abusing tik in Cape Town: the experiences of healthcare providers

ORIGINALITY REPORT

%7	%0	%1	%6
SIMILARITY INDEX	INTERNET SOURCES	PUBLICATIONS	STUDENT PAPERS

PRIMARY SOURCES

1	Submitted to University of Stellenbosch, South Africa Student Paper	%6
2	Textbook of Addiction Treatment International Perspectives, 2015. Publication	%1